

“I Got Peace and Stability”: Women’s Perceptions of Contraceptive Use in Sidama, SNNPR, Ethiopia

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University of Saskatchewan Saskatoon

By

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ABSTRACT

Most of the documented benefits of contraceptive service lack in-depth exploration of the lived experiences of service users. This study of contraceptive users in the Sidama Zone, Southern Region, Ethiopia; was conducted with the aim of improving the overall understanding of contraceptive use towards women's health and empowerment. This knowledge enables alignment of contraceptive service provision with the International Conference on Population Development declaration of rights-based approach.

The study employed a mixed method design. The quantitative aspects include use of a descriptive retrospective approach to generate a five year snapshot contraceptive use from health institutions. Percentages were used to compute the contraceptive prevalence in the last five years. The bulk of the study was a qualitative design using interpretive phenomenology- guided by a Heideggerian approach. Data were collected using key informant interviews, focus group discussions and individual in-depth interviews. Data were analyzed using an interpretive phenomenological analysis with hermeneutic circle approach. Results were presented in broad themes following the study questions.

The findings of the study indicated that contraceptive use in the study area is steadily improving. In 2008 contraceptive prevalence was twenty- five percent and after five years, it reached forty- two percent. Injectable contraceptive is the leading method, with nearly three-fourth of current users on this method. Recently, every health post offers at least one long acting and two short acting methods. The qualitative finding revealed that women's experiences regarding the benefits of contraceptive use is encouraging. Women explicated that contraceptive service is an emancipatory and transformative experiences for them as it enabled them to control their bodies, reproduction and fertility by averting unwanted pregnancy thereby engaging in various socio-economic, religious, and political affairs. Controlled fertility gave them more time to plan their livelihood issues. The study's title, a participant quote, captures the sentiment well: "*we got peace, rest and stability*". The study finding further revealed the unique contributions of the health extension program in improving access and convenience to contraceptive service by removing many cultural, gender, and linguistic barriers.

The study concludes that contraceptive service pattern has improved greatly in access and coverage; however, the majority of current users are merely on a single method indicating gaps in expanding contraceptive method mix. Women's experiences about internalizing contraceptive

use benefits towards their empowerment and health are encouraging in that they wholeheartedly expressed that the service is emancipatory and transformative. However, there are grey areas from the perspectives of ensuring support from men and dominant community members such as elders. Moreover, there is observed disconnect in conceptualizing and practicing contraceptive service provision from a broader human rights premises among health care workers across the service delivery hierarchy.

The research recommends the establishment of smooth and functional mechanisms to ensure all stakeholders involved in service provision develop a shared understanding about the human rights rationale and practice while providing contraceptive service. More efforts are needed to ensure sustainable contraceptive service use by removing the existing cultural and gender barriers. Efforts should be amplified to increase men's involvement in the reproductive services. Further study is recommended to investigate the nature and factors that influence the incorporation of human rights rationale across the health care system.

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DEDICATION

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LIST OF ABBREVIATIONS

AD	After death or a Latin word <i>anno domini</i> which means in the year of our Lord
BA	Bachelor of Art
BC	Before Christ
BSc	Bachelor of Sciences
CFDRE	Constitution of the Federal Democratic Republic of Ethiopia
CHW	Community Health Worker
CIA	Central Intelligence Agency
CPI	Client Provider Interaction
CPR	Contraceptive Prevalence Rate
CSA	Central Statistical Authority
EC	Ethiopian Calendar
EDHS	Ethiopian Demographic and Health Survey
EPDRE	Ethiopian People's Democratic Revolutionary Front
EPI	Expanded Program of Immunization
FGD	Focus Group Discussion
FGAE	Family Guidance Association of Ethiopia
FHI	Family Health International
FP	Family Planning
FMOH	Federal Ministry of Health
GA	Graduate Assistant
GC	Gregorian calendar
GDP	Gross Domestic Product
GNI	Gross National Income

GNP	Gross National Product
HEP	Health Extension Program
HEW	Health Extension Worker
HMIS	Health Management Information System
HSDP	Health Sector Development Plan
HwU	Hawassa University
ICPD	International Conference on Population Development
IMR	Infant Mortality Rate
IPA	Interpretive Phenomenological Analysis
IPPF	International Planned Parenthood Federation
IRB	Institutional Review Board
IUCD	Intra Uterine Contraceptive Device
KII	Key Informant Interview
KM	kilometer
LB	Live Birth
MD	Medical Doctor
MDG	Millennium Development Goals
Med	Master of Education
MMR	Maternal Mortality Ratio
MOFED	Ministry of Finance and Economic Development
MPH	Masters of Public Health
MS	Micro-soft
MSH	Management Science for Health
NFPS	National Family Planning Survey
NGO	Non- Governmental Organization

NMR	Neonatal Mortality Rate
OCP	Oral Contraceptive Pill
PI	Principal Investigator
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PhD	Doctor of Philosophy
PFSA	Pharmaceutical Fund and Supply Agency
PPFA	Planned Parenthood Federation of America
PRB	Population Reference Bureau
RHB	Regional Health Bureau
RH	Reproductive Health
SNNPR	South Nations Nationalities and People's Region
TFR	Total Fertility Rate
TGE	Transitional Government of Ethiopia
TTBA	Trained Traditional Birth Attendant
UN	United Nations
UNFPA	United Nation Fund for Population Authority
UNICEF	United Nation Children's' Fund
UNESCO	United Nation Education, Sciences and Culture organization
USAID	Units State's Aid for International Development
VSC	Voluntary Surgical Contraceptive
WHO	World Health Organization
WSP	Women Study Project

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DEFINITION OF TERMS

Birth control: involves one or more actions, devices, sexual practices or medication followed to intentionally prevent or reduce the likelihood of pregnancy or child birth. The three main routes of birth control to control or end pregnancy include contraception (the prevention of fertilization ovum by sperm cell), contragestion (preventing fertilized egg from implantation), and the chemicals or surgical induction or abortion of the developing embryo/fetus (WHO, 2007).

Contraception: is defined as the use of various devices, drugs, agents, sexual practices or surgical procedures to prevent conception or impregnation (pregnancy) (WHO, 2007; Seltzer, 2002).

DMPA (depot-medroxy progesterone acetate) also known as *Depo – provera*: which is given every three months. It contains a progestin, similar to the natural hormone that woman's body makes.

Empowerment: is the process by which the powerless gain greater control over the circumstances of their lives (Naryana, 2002; Batliwalla, 1994).

Women's empowerment: is defined as “women's ability to make strategic life choices where that ability had been previously denied them” (Kabeer 1999).

Family planning: according to WHO (1971), is defined as “a way of thinking and living that is adapted voluntarily upon the bases of knowledge, attitude, and responsible decisions by the individuals and couples in order to promote the health and welfare of the family group and thus contributes effectively to the social development of the country” (Klaus, 1995).

Gender: is defined as a set of characteristics, roles, and behavior patterns that distinguish women from men socially and culturally, and relations of power ascribed to them (Krieger, 2003).

Gender relations: is a necessary element of all social relations -- domestic, labor, political or economic.

Implant: is small plastic rods or capsules, each about the size of a matchstick, that release a progestin like the natural hormone progesterone in a woman's body.

Implanon: is a family of implant contraceptive method with one rod placed sub dermally in the upper arm of a woman, effective for 3 years.

Intrauterine devices (IUCD): are small flexible devices made of metal and/or plastic that come in different shapes and sizes and are inserted in the uterus through the cervix. The various shapes include ring, loop, spiral, T shape, 7 shape and others. Some are coated with copper, and some

contain small amounts of the female hormone progesterone. Most IUDs have a short "tail" or string that the women can feel by putting her fingers into her vagina. The most commonly used type in most countries including Ethiopia is Copper 380A.

Oral contraceptive pills: are pills that a woman takes by mouth to prevent pregnancy. Types of Oral Contraceptives Pills: Pills which combine synthetic hormones estrogen and progestin, commonly called combined oral contraceptives, and pills which contain no estrogen, commonly called progestin only pills.

Reproductive health: is defined as a complete state of physical, mental, and social well-being in all matters relating to the reproductive process, function and system at all stage of life but not the absence of disease or infirmity. Reproductive health, therefor, implies that people are able to have a responsible, satisfying, and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how to do so. (ICPD Programme of Action, Paragraph 7.2, 1995)

Sexual and reproductive health rights: are the right for all people, regardless of age, gender and other characteristics, to make choices regarding their own sexuality and reproduction, provided that they respect the rights of others. It includes the right to access to information and services to support these choices and promote sexual and reproductive health (SRH). (WHO 2004)

Tubal ligation/ female sterilization: is a permanent contraception for women who will not want more children. The procedure is done surgically.

Definition of Ethiopian local terms

Dega: is a localized classification of a given area based on the ecological and climatic condition that equate to high land.

Dergue: is a regime before the current government took place from 1966-1983 (Ethiopian calendar) 1974-1991) Also known as the military government or socialist revolutionary government.

Idir: is a self-help traditional association in Ethiopia that supports families financially, materially, and emotionally in a time of bereavement.

Kebele: is the smallest administrative unit that holds a population of about 5000. This was termed as a peasant association during the Dergue regime.

Kuteba: is equivalent to saving and *kutema mahiber* is an association that administers collective saving be that at the community level or at the work place.

Qola: is a term used to describe the geographic area based on the ecological and climatic conditions in the low land.

Woinadega: is a term used to describe the geographic area based on the ecological and climatic condition equivalent to the middle land.

Woreda: is a second administrative hierarchy usually equivalent to the district or county. It usually holds a total population of about 100,000 and above.

Special woreda: is that which has an equivalent administrative hierarchy to that of the zone but is smaller than a zone both in catchment area and population size. It got the special name and hierarchy due to the special nature of the *woreda* people who are socio-culturally distinct from others

Zone: is the third administrative hierarchy next to the *woreda* and directly accountable to the region.

MAPS OF THE STUDY AREAS (Country, Region and Study Zone) adapted from Hawassa University –community linkage document

1



Figure 1. Map of Ethiopia indicating administrative regions

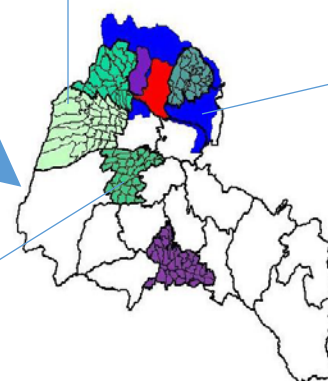


Figure 2. Map of SNNPR administrative zones and special woredas

Boricha Woreda

Wondogenet Woreda

Dale Woreda



- Sidama
- Lake Hawassa
- Wondogenet
- Hula
- Dale
- Hawassa Zuria
- Hawassa town
- Boricha
- Hawassa watershed

Figure 3. Map of Sidama Zone indicating University research villages

Source: Hawassa University

PREFACE

I was born in 1961¹ (EC/1969 GC) to a rural family in the southern west part of Ethiopia in a special place called Wolaita. My father and mother jointly had four children of which I am the second in birth order. Three of us are males and the last one is a female. I am also fifth in birth order out of the seven live children born to my parents. This is because both of my parents had another marriage out of which there were three additional children each. Unfortunately, three of my mother's older children from the early marriage died in childhood. I do not exactly remember the causes of their death and their age at death.

There was big age gap between my mother and my father. My father did not have a male child before my mother gave birth to my immediate older brother. My brother was unlucky to come in that order, for my father had been waiting for a son with whom to share the burden of his now advanced years. I was fortunate enough to be born afterward. With father's attention already focused on my brother, I was able to remain very close to my mother. It seemed like a sort of competition between parents among sons: my father concentrated on my older brother, and my mother on me. As a result of this attention, my mother sent me to school as I reached the age of five, a year after I stopped breastfeeding. I was breast-fed the longest out of all my siblings; this prolonged contact perhaps drew me closer to her.

Like most rural parents, and because of their age difference, my mother and father's marriage was full of conflict. From a very young age, I remember my father frequently beat my mother, and as a result sometimes she moved to her parent's house, leaving us alone. Those times without her were very hard for us. The most surprising issue was, beaten women were never expected to defend themselves. Societal norms dictated that women had to submit, and simply put up with being beaten. If a woman were to resist her husband, other males from the neighborhood would beat her in support of her husband. This was the case for my mother. Therefore, I started to think about the condition of women from a very early age, and began to strengthen my relationship with my mom. I began to defend her verbally when my dad abused her.

¹ EC is an Ethiopian Calendar, with thirteen months in a year. Twelve months have thirty days and the last month has 5 days for three consecutive years and at the fourth year has 6 days. The Ethiopian new year begins on September first (September ten or eleven in the Gregorian calendar (GC)). The Ethiopian calendar is seven years behind the GC. The calendar in the text of this thesis is the GC but I suggest readers of this text take into consideration the difference between the EC and GC.

My older brother and I were very close, not just like any brothers, as we had grown as both friends and brothers. We remained open to discuss whatever matter we wanted to, and if we failed to reach consensus, we would bring it to our mom. For example, we had one special dialogue related to reproduction. The dialogue took place around the time I was age seven or eight. It was about how conception takes place regularly. I said, *‘a husband and a wife do sexual intercourse only during their wedding time and conception then takes place in regular order by itself’*. My brother argued with me stating that it is not like that. He said, *‘for a conception to take place, a husband and a wife should have intercourse every time’*. I was not convinced of his idea and we took the matter to our mom. She then explained he was correct.

More organized thinking about reproductive health in general and family planning in particular appeared to me around the time I was an eleventh grade student. A person from the provincial Family Guidance Association of Ethiopia (FGAE) came to our high school and taught us about family planning in 1984. A year later, as part of primary health care, a five - day training including family planning was given to all grade twelve students before we were deployed to the 17th literacy campaign as volunteers. Along with the literacy campaign, we the student campaigners, ‘zemachoch’, were given responsibility to raise public awareness about primary health care, including family planning. I was a coordinator for one peasant association/*kebele* literacy campaign and mandated to effect all activities. Henceforth, my interest grew stronger as I started teaching the adult learners about family planning together with the main literacy campaign.

One of my experiences while teaching men’s class about family planning is worth mentioning here. I taught on all existing contraceptive methods including the natural and artificial methods. In explaining about coitus interruptus as one of the (not very effective) methods to control fertility, a man raised his hand and said to me: “*Gash*² Abraham what do you mean? Do you think me to withdraw in the middle of that pleasurable act? Why don’t you pierce me with a sword instead?”

After the four-month campaign, results for our school exit exam were disclosed and I was assigned to a comprehensive nursing training for three years. I took nursing training between 1988 and 1990. The ministry of health then deployed me to the remotest health center. That health center was inaccessible by modern transportation means and as a result I was forced to

² ‘Gash’ is an Ethiopian prefix usually used to show respect for people with presumed status.

walk for one and half days (108 Kilometer (KM)) on foot from the nearest town. The health center had thirteen satellite health stations scattered about the surrounding region. Of those, the furthest away was five days walking distance, whereas the nearest was six hours.

In May 1990, the regional health bureau offered me an additional training opportunity on reproductive health, including family planning, for one month at the FGAE training center in Addis Ababa (the Capital of Ethiopia). This training increased my commitment towards family planning. When I returned to the health center, I was assigned as a coordinator for maternal and child health service for about 500,000 people living in the three districts. During this time the national contraceptive prevalence rate was only two percent. In the remotest areas, such as where I was assigned, there was no clear data to indicate the coverage. So I established a family planning service to the people most in need, and included family planning in outreach activities with the expanded program of immunization (EPI). I promoted family planning service in all areas where I worked for five and half years until I again joined the training institution to pursue a baccalaureate degree in nursing. This was 1996.

After graduating with a B.Sc. in nursing, I began working in one of the higher training institutions of the nation as a graduate assistant (GA), where I taught courses in obstetrics and gynecology nursing, family health, and ‘introduction to public health nursing’ for the public health nursing diploma program. After three years of service in the college as both a graduate assistant and assistant lecturer, I joined Addis Ababa University to pursue an MPH degree. I was awarded an MPH in July 2003. My master degree thesis was on family planning. After that, I worked as a lecturer and assistant professor in the school of nursing at Hawassa University. I taught courses on reproductive health and health services management.

Overall, my early child life experiences, involvement in direct reproductive health service provision, and teaching and research experiences have together created a strong commitment and close acquaintance to rural Ethiopian women and their challenges. It is from this underlying experience that this PhD dissertation topic emerged.

CHAPTER 1-INTRODUCTION

As historical sources illustrate, contraceptive use has existed since the time of early human beings (Genesis, 38: 7-10; Robinson, 1990; Whiterlaw, 2000). Women and men have used contraceptives to prevent pregnancy and control fertility for centuries (McLaren, 1990; Walby, 1990) although the effectiveness of the methods is contested during the early periods (Riddle, 1997). Well organized modern contraceptive provision in the health systems started around 1960 (Cleland, 2008). At that time, international agencies primarily promoted programs in developing countries using a demographic rationale: to harmonize population growth with the economic development and natural resources in a given region or country (Robinson & Ross, 2007). The programs later embraced two other rationales that had already been adopted in many western countries. These are the health rationale and the human rights rationale, introduced in the 1980s and 1990s, respectively (Robinson & Ross, 2007).

In Ethiopia, a group of volunteers started contraceptive service provision in 1966. The idea was to regulate unplanned and unwanted fertilities by bringing about harmony in the fertility, population growth, health, and economic development of women, families, and communities at the national level (Family Guidance Association of Ethiopia (FGAE), 2012; UN, 2002). However, in its early years contraceptive provision encountered challenges for various reasons. Of note, Ethiopia is a patriarchal state where women occupy a very low status and where there is a dominant influence of religious belief (FGAE, 2012).

Consequently, the vertical nature of contraceptive service delivery, together with inadequate government and community commitment, seriously curtailed the expansion of service to the majority of Ethiopia's population until the current government's recently devised reproductive health service delivery strategy. Under the broad new health policy, this strategy, together with other health services strategies enabled the integration and expansion of contraceptive services to different parts of the country. In this dissertation, I explore the experiences and perceptions of women who have been partaking in such services in the Sidama Zone, South Nation, Nationalities and People's Region of Ethiopia. What follows introduces the reader to Ethiopia, its health system, the immediate context of the study, and the underlying problem that led to this research.

Background of the Study Area

Ethiopia is located in the horn of Africa between 3-15° N latitude and 33-48° E longitude. It is bordered by Eritrea in the north and north east, Djibouti and Somalia in the east, Kenya in the south, Sudan in the west, and South-Sudan in south west. Ethiopia is the oldest independent country of Africa and among the most ancient and historical countries in the world. It is credited as being the origin of mankind (Edey & Johanson, 1990). The country covers approximately 1.1 million square kilometers. The population is estimated to be approximately 92 million people, with more than fifty percent under 20 years of age (Central Intelligence Agency (CIA) 2012). The average number of inhabitants per km² is 49, ranging from 10 persons per km² to more than 1000 in rural highlands. The annual population growth rate is about 2.86 percent (CIA, 2014). The capital city of Addis Ababa has a population of approximately 3 million people. Like many other African countries, Ethiopia is a multi-ethnic multi-lingual state, with 83 languages spoken and 200 dialects (CSA, 2007).

Agriculture is the backbone of the country's economy. The principal exports are coffee, oil seeds, pulses, flowers, vegetables, sugar, and foodstuffs for animals. About ninety percent of the population earn their living from the land, mainly as subsistence farmers. Ethiopia has a high central plateau that varies from 1800 to 3000 meters above sea level, with some mountains reaching 4620 meters. The climate is temperate on the plateau and hot in the low lands. Addis Ababa ranges from 2200 to 2600 meters above sea level; maximum temperature is 26 degree Celsius and minimum 4 degree Celsius (Camberlin, & Philippon, 2001; CIA, 2012).

Ethiopia is a Federal Democratic Republic with a parliamentary system. Members of the House of Representatives are elected from the regions, zones, *woredas* (districts) and *kebeles* (sub districts). The members of the House of Federation are designated from their respective nations and nationalities. The highest governing body of each national regional state is the Regional Council. Administratively the country is divided in to nine regional states and two city administrations. The regional states are: Oromiya, Amhara, Southern Nations and Nationalities and Peoples Region, Tigray, Somalia, Benishangul and Gumuz, Gambella, Afar and Harari while Addis Ababa and Dire Dawa are city administrations (FMoH, 2007/08). (For detail see the maps. p. xix)

The Ethiopian health care system. Ethiopia has a pluralistic health service delivery system that recognizes the existence of multiple routes for accessing health services (Bekele, Rasschaert, Assefa, Berhene, & Damme, 2011; Bloom & Standing, 2001). The history of health services for Ethiopia goes as far back as the 16th century (Berhan, 2008; Kassie & Kloos, 1993) but the organized health service delivery was established in 1948, a year concomitant with the launching of the World Health Organization (WHO) in 1948 (Mehari, Gebeyehu, & Asfaw, 2012; FMOH, 2008; WHO, 1948). Health service delivery approaches in Ethiopia have exhibited various modalities (Mahari, et al., 2012; Kloos, 1998). In its early stage of service delivery, the country used a vertical service delivery model for some selected health programs such as the eradication of malaria and smallpox, prevention and control of venereal disease, and control of tuberculosis and leprosy (Gish, 1992; Kassie & Kloos, 1993).

After the vertical model came the basic health service delivery approach. The main aim of this approach was to expand basic health services to the rural population through building health centers³ and health stations, and in the training and deployment of health professionals. Under this plan, teams comprised of three health professionals were assigned to each health center, and one health assistant to each health station.⁴ The basic health service approach existed from 1950s- the early 1970s, until the Primary Health Care (PHC) approach launched (Kitaw, Teka, & Muche, 2013).

Ethiopia adopted the primary health care approach in 1980, two years after the joint launching of primary health care by WHO and UNICEF in Alma-Ata in 1978. Since then, PHC has been the backbone of Ethiopian health service delivery, with certain amendments to suit the country's context (Kitaw et al., 2012; Kloss, 1998).

Modern health service delivery in Ethiopia developed over three political regimes (Kloos, 1998). The first one was the feudal prototype government headed by His Majesty HaileSELLASIE (1930-1974) [Hodes & Kloos, 1988]. By popular upheaval, the HaileSELLASIE reign was overthrown and the Military *Dergue* took the power. The *Dergue* followed the socialist

³ A health center is a health institution meant to provide some curative, preventive and health promotion services for 50-100,000 population, but in actuality they are serving approximately 25,000. The health center was run by a three-person team (the health officer with B.Sc. training in public health, the sanitarian, (a diploma level education) and a community health nurse (a diploma level education).

⁴ The health station was mandated to serve 10,000 population and was run by a health assistant. A health assistant was a health professional who got training for 18 months after completing 10th grade education. It is important to note that there is no health professional called health assistant at this time in the health system. Some are upgraded to nursing and others have been retired.

revolutionary political path, much like the then-known Eastern block. The *Dergue* government ruled the country for seventeen years (1974-1991). The whole *Dergue* reign was known for its long civil war between the rebel group from the north and the ruling government. The war was a contributing factor in the very weak health system and low service coverage, with high morbidities and mortalities. Nearly sixty five percent of the national budget was allocated to the military services during this time (Kloos, 1992).

The current government came into power in 1991 by overthrowing the *Dergue* reign with rebel army forces (Kloss, 1998; Ayalew, 1991). After receiving the responsibility of country's governance, the Ethiopian People's Democratic Revolutionary Front (EPDRF) envisioned a means for improving the health of the country's population compromised by the war and other natural and man-made calamities (Kloos, 1998). After a critical evaluation of the nation's health systems and health outcomes (which were at a very low level on many measures), and considering local and global contexts, the transitional government came up with a new health policy. The health policy was formulated on the premises of democratization and decentralization in the belief that health is both a human right and a core aspect for development. Thus, failure to ensure access to basic health service is a denial of natural human rights and allows the perpetuation of poverty (Transitional Government of Ethiopia (TGE), 1993).

The policy also articulated the main attributes of identified health problems and offered the means to solve them. The policy indicated the intention to widen the scope of interventions and provide means to involve people in their health matters. Unlike its predecessor, the current policy framework has created a much flatter health service delivery hierarchy, ensuring better referral service networks. The former six tiers framework was shortened into a three-tier structure (see fig.4 P. 6). The policy also directed the development of a 20-year Health Sector Development Plan (HSDP) divided into five phases, each with a five-year duration (Barnabas & Zwi, 1997; Federal Ministry of Health (FMOH), 2005; FMOH, 1997; TGE 1993; Wamai, 2008).

In 2010, the country had implemented three phases of its HSDP and is currently embarking on a fourth phase. Expansion of health infrastructure and the training and deployment of health workforces to the ends of the policy are initiatives that fall under the umbrella of PHC (FMOH, 2010; WHO, 2008). This development plan has contributed to the current level of health service coverage and underlying human resource and infrastructure development (see table.1, p. 7). The government has given major emphasis to improving access

to the most disadvantaged groups of society (the rural dwellers and marginalized groups, victims of natural and man-made calamities) through the Health Extension Program (HEP), an innovative community-based primary health care approach, and the integration of services at health institution and community levels (FMOH, 2005; Mekibib, 2008; World Bank, 2009). The government also decentralized health administration to the district level, and expanded health programs in such a way as to encompass essential health services packages (USAID, 2012).

The Health Extension Program (HEP) was launched in 2003 with the purpose of providing accelerated expansion of health services by recruiting women from their resident *kebele* (who had completed 10th grade (high school education), at least). The HEP offers training to the women recruits for one year and then deploys them back to their *kebele*. The women return as health extension workers, public employees working fulltime in the community-based health institution, the health post⁵, and community health services, including home visits (FMOH, 2005).

The health extension program aims to establish at least one health post and deploy two women health extension workers in every *kebele* with a total population of 5000. A health post is part of a primary health care unit (PHCU). Initially, the health center and five satellite health posts (anticipated to serve a population of about 25,000) were categorized as a primary health care unit (FMOH, 2007). By creating PHCUs, the government claims to have raised physical accessibility of service to more than ninety percent in 2011, up from its previous sixty four percent in 2004 (Teklemaimanot & Teklehaimanot, 2013). A recent change sees PHCUs encompassing the rural/district hospitals that act as referral centers for other primary health care institutions. This amendment has been made with the intention of improving maternal and neonatal health through improved access to safe motherhood (FMOH, 2010).

The health extension program has 16 packages/components of health services to be carried out by the health extension workers in collaboration with the community members (Banteyerga, 2011). These 16 components are in turn categorized into four major areas. One of these four areas is reproductive health, including family planning/contraceptive services (FMOH, 2007). The complexities and types of family planning services at the community level have increased over time (Birhanu, Godesso, Kebede & Gerbaba 2013). At the early stage of the HEP,

⁵ A health post is a grass root level public owned health institution mandated to serve for about 5000 populations and run by the health extension workers.

the health extension workers were providing health education, oral contraceptive pills, and condoms. The service has since been enriched to include long acting methods such as implanon, with health extension workers trained to insert it (Yitayal, Berhane, Worku, & Kebede, 2014).

Unlike the former strictly institutional health services, contraceptive service and health extension packages are jointly implemented with the active participation of community members. Community members are organized on the existing administrative hierarchy of the *kebele* down to the household level. In every *kebele*, a ‘development armies’ encompass some thirty households which divide in to a one-to-five network, where one model household coordinates five other households. Women comprise the development armies and model households (Yitayal et al., 2014).

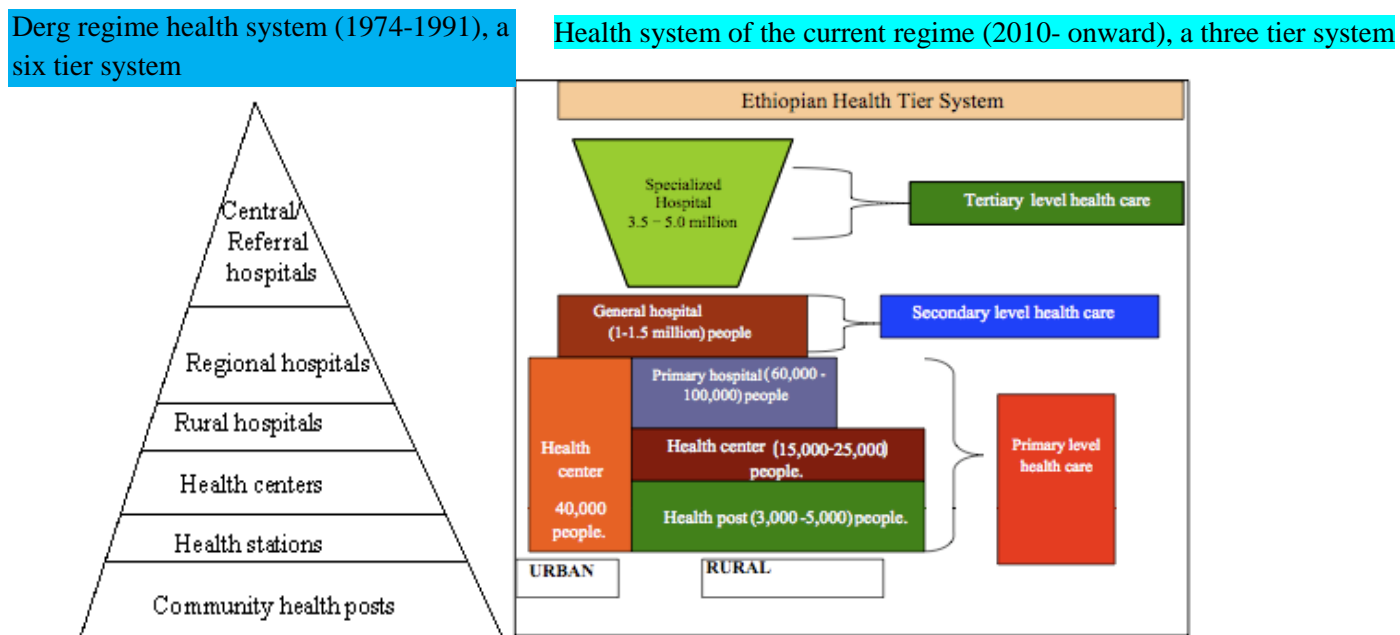


Fig. 4. Hierarchy/tiers of health service system during the two political systems (adopted from the Federal Ministry of Health). Source: Ethiopian Federal Ministry of Health.

Table 1. Health and Related Profile of Ethiopia

Description of Indicator	Value/measurement
Population growth rate	2.89%
Birth rate	37.66 births/1000 population
Death rate	8.52 deaths/1000 population
Urbanization	17%
Life expectance at birth	60.75 years (total)
IMR	55.77/1000 LB
MMR	420/100,000 LB
CPR	27% (modern methods)
Health expenditure	4.7% of the GDP
Physician density	0.03/1000 population
Hospital bed	1.3 beds/1000 population

Study area profile. This study was conducted in Sidama Zone, which is one among the thirteen zones in the Southern Nations Nationalities and People's Regional Government (SNNPRG), under the Federal Democratic Government of Ethiopia. Sidama is located in southeastern part of the region bordered on the south by the Oromia Region, except for the short stretch in the middle, where it shares a border with Gedeo Zone. On the west, it borders Wolaita Zone, and on the north and east again the Oromia Region. Hawassa, the capital of the zone as well as the region, is situated 275 km south of Addis Ababa on the main high way to Moyale, Kenya (CSA, 2007). According to the population projection based on the 2007 national population census, the zone has a total of 3,471,568 people of which 1,753,142 (50.5 percent) are males and 1,718,426 (49.5 percent) are females. Women of reproductive age are estimated to be 23.8 percent of the total population. Household population size is estimated to be 4.7(CSA, 2007). Annual population increase is estimated to be two point nine percent (Sidama Zone Health Profile, 2012).

Out of the total population, ninety- four percent are rural and 6 percent are urban dwellers. The average population density is 521 persons/ km². The major ethnicities of the zone

are Sidama, which comprises 88.6 percent of the whole, followed by Amhara, Oromo, Wolaita, and others. Administratively the zone is divided into nineteen districts and two city administrations. In turn these are divided into forty urban *kebeles* and 536 rural *kebeles*, which are the lowest administrative unit. All the districts are accessible by all-weather roads; almost all districts have telephone and postal services (CSA, 2007) (For details, see the map of Sidama zone on page XIV, fig.3, p.xix). The climatic condition of the zone is divided into *Dega* (highland), *woinadega* (middle land) and *qola* (low land). The majority of the zone is covered by *woinadega* (middle land), at fifty four percent. Similar to other rural zones of Ethiopia, the economic situation is based on subsistence and cash crop production, coffee being the main crop.

Physical health service coverage is considered universal in the zone when taking into account the availability of a functional health post in every rural *kebele*. Overall, the Zone has 3039 health professionals of all kinds, including health extension workers. Despite the encouraging progress in the expansion of primary health services, higher level health services have not yet reached the desired level. There exists a large discrepancy in the presence of physicians and other senior health professionals. This is illustrated by a present physician to population ratio of 1:149,450. This figure shows the difference between present reality and the WHO standard. The Zone has only one Zonal Hospital and one district hospital that are currently fully functional (Sidama Zone Health Profile, 2012).

Sidama Zone health professional and health institution profile

Table 2. Sidama Zone Health Professionals Profile

Description of health professional	Quantity	Population ration
All forms of physicians including specialities	24	1:149,458
All forms of diploma nurses	1023	1:4419
Certificate nurses	349	
degree nurses including midwives	32	1:102,753
Health officer	106	1:51376
Pharmacist	6	
Druggist	188	
Certificate pharmacy technician	18	
Medical laboratory technologist	19	
Medical laboratory technician (diploma)	154	
Medical laboratory technician (certificate)	5	
Dentist	2	
Psychiatry nurse	2	
Radiologist	3	
Radiography technician	3	
Ophthalmic nurse	2	
Anaesthesia BSc	3	
Anaesthesia dip	1	
Environmental health professional	9	
Environmental health technician dip	22	
Health educationalist	1	
Health extension worker	1333	1: 3013
Total	3093	

Table 3. Sidama Zone Health Institutions Profile

Description of health institution	quantity
Zonal hospital	1
District hospital	2
Health center	101
Health post	526
Private clinic	99
Drug store	35
Rural drug vender	89
NGO clinics	7
Total	859

Hawassa, the capital city of both the South Nations and Nationality and People Regional Government (SNNPRG) and Sidama Zonal administration, is one of the fastest growing cities of the country. The city encompasses numerous public and private institutions, NGOs and international agencies. Among the higher educational institutions situated in Hawassa city, Hawassa University is prominent. It has existed for more than three decades.

In line with the National Higher Education Transformation Plan, Hawassa University has recently undertaken a serious evaluation of its accomplishments. In doing so, the university recognized that it has been involved in doing multidisciplinary research largely for academic purposes; however, these research projects did not meet the needs and priorities of the local community (Hawassa University Reform Document, 2012). Recognizing these disparities, the University embarked on a massive community outreach program by establishing six technology villages (*woredas*) in which appropriate technologies in different fields of studies will be generated and transferred to the community. The thematic areas of concern were Socio-Economic and Natural Resources, Health, Agriculture, Education and Business, Industry and Technology.

To improve the relevance of the University's research and development programs to meet societal needs and contribute to academic excellence, the University declared its intention to work with all stakeholders in the selected technology village areas with the aim of ensuring the contribution to the development of local communities and demonstrating a positive impact within the five years (2011-2016) of the program. In connection to the above notion, the University offered PhD opportunities for senior lecturers to pursue their study and conduct dissertation work in the technology villages (Health and Health Related Baseline Survey for Six Technology Villages of Hawassa University, unpublished). I am one of the staff members of Hawassa University who received the benefit of this scholarship. In accordance with the home university research and community development plan, this study was conducted within the selected research sites mentioned above. Embedded in that larger context, this study has emerged to underscore health, with particular emphasis on contraceptive utilization and its related benefits, as one of the important thematic areas identified jointly by Hawassa University and collaborating entities (regional health bureau, zonal health department, districts health offices other sector organizations, and local communities).

Statement of the Problem

As different studies indicate, when population increases were unregulated, the economic status of both the family and the nation are weakened (Gold, Sonfield, Richards, & Frost, 2009). When the numbers of children surpass a family's economic capacity, the family cannot send all their children to school, fail to offer enough food, and are unable to seek health care (Portner, 2010; Yang, 2009). Further, the country cannot provide jobs for all its citizens (Schultz, 2005). It also weakens the capacity of women by taking their time and energy that can be otherwise spared for economically gainful activities and thus perpetuates the vicious cycle of poverty (Schultz, 2005). Similarly, fast population growth reduces the capacity of a nation to improve its per capita GNP (Ministry of Finance and Economic Development (MOFED), 2006; TGE, 1993). Much of this unregulated and rapid population growth takes place in the least developed parts of the world. Ethiopia is categorized thus, and shares the burden of unregulated fertilities (Eastwood & Lipton, 2001; CSA, 2011; PRB, 2011; PRB, 2008).

Modern contraceptive methods use has been documented since the early 1960s (Cleland, 2008; Darroch, Singh & Nadeau, 2008), albeit with varying level of utilization around the world (Sitruk-Ware, 2006). According to the recent available evidence, the current contraceptive prevalence rate (CPR) varies from three percent in Chad to eighty- eight percent in Norway. This variation is not only evident among nations or regions but also within the same country from one area to another. The current average global contraceptive prevalence rate is 63 percent. With regard to the global distribution of contraceptive prevalence, developed nations have a relatively better rate (seventy percent) than the less developed nations (sixty- two percent). The major exceptions are sub-Saharan Africa, Melanesia, Micronesia, and Polynesia, where the estimated levels of contraceptive prevalence are still below thirty percent. As a region, sub-Saharan Africa has the lowest level of contraceptive prevalence, with only twenty- one percent of women of reproductive age who are married or in union using some methods of contraception (Alkema, Kantorova, Menzzi, Biddelecom, 2013; Darroch, 2013; Rosss & Adelaja, 2005; UN, 2009; WHO, 2014).

Like most nations in sub-Saharan Africa, the contraceptive prevalence rate of Ethiopia can be described as very low, though the services have been in place for the past four decades (FGAE, 2012; Hailemariam, Mekibib & Fantahun, 2005; Ross, Hardee Mumford & Eid, 2011). The trend of contraceptive utilization manifests slow progress. In 1990, the contraceptive

prevalence was four percent and reached eight percent in 2000. According to the 2005 Ethiopia Demographic and Health Survey (EDHS), it had grown to fifteen percent (2005) and has currently reached twenty- seven percent (2010) with the most remarkable improvement ever seen (Abraha & Nigatu, 2009; CSA 2000; CSA 2007; CSA 2011; CSA 1993).

However, the observed improvement in contraceptive prevalence rate (CPR) in Ethiopia in 2011 is not uniform across the regions. For instance, CPR among urban women has only slightly increased in the last five years (forty- seven to fifty -three percent); while it doubled from eleven percent in 2005 to twenty three percent in 2011 among rural women. The biggest differences in levels of contraceptive use are observed across regions. For example, Addis Ababa has the highest CPR at sixty three percent, which is equivalent to the global average for developing nations. About one-third of married women in Amhara, Gambela, Harari, and Dire Dawa are using contraception, the corresponding rate in both Affar and Somali is below ten percent (CSA, 2011). The Southern Nations Nationalities and People's region, where the study was conducted, has a relatively low contraceptive prevalence rate (twenty- five percent) compared to the best performing regions like Amhara (thirty- three percent) and Addis Ababa city administration (sixty three percent) (CSA, 2011).

Perhaps unsurprisingly, given the diversity in Ethiopia in terms of geography, culture, ethnicity, religion, and many other social and economic parameters, wide differences exist between the urban and rural dwellers in all social services accessibility such as education and health (CSA, 2011; CSA, 2008). Political and administrative trends in Ethiopia also create power differences between women and men, denying the right and privileges of women (although the current government has attempted to change that through its constitution of 1995). Many additional circumstances affect the status of women and girls, and gender equality between women and men. These factors have been contributing to the difference in contraceptive utilization across the country from region to region, urban to rural dweller, and educated versus uneducated (MOFED, 2006; Stephenson, Bartel, & Rubardt, 2012).

Recent investigation of the differences in contraceptive utilization conducted by Mekonnen and Worku in Central South Ethiopia (2011) revealed that contraceptive use is affected by factors such as access, religion, and quality of services including providers' attitude and competence, the ease of use of the methods, the women's dietary condition, and workloads. Low levels of education and lack of discussion between men and women in Ethiopia further

hinders contraceptive use (Beekle & Mc Clabe, 2006; Haile & Enkuselassie, 2006; Korra, 2002; Mekonnen & Worku, 2011; Sedgh & Hussain, 2014). Additionally, lack of comprehensive knowledge about the benefits of contraceptives to the wider domains of women's lives, inadequate support from the husband/spouse, low service quality, and limited types of contraceptive methods affect contraceptive usage rates (Mesfin, 2002; Short & Kiros, 2002; Wubshet, Lemma, Antoni & Cherinet, 2008). Taken together, such studies suggest that the earlier demographic rationales for promoting contraceptive delivery was too narrowly focused on population issues in terms of demographic transition, and disregarded the broader dimensions of women's reproductive and human rights. The narrow focus isolated family planning from the broader efforts to change the subordination of women; hence, it was ineffective in reducing the low contraceptive use, high fertility, and low status of women (Jacobson, 2000). Notably, Ethiopia is still suffering from the preventable morbidity and mortalities of mothers and newborns with one of the highest maternal mortality rates (MMR) (420/100,000 LB), neonatal mortality rates (NMR), high total fertility rates (4.6 children per life time of the woman), and highest unmet need for family planning (twenty six percent) in the world (CSA, 2011; World Bank, 2012).

The picture is thus mixed. Despite some encouraging efforts and recent progress in improving access to reproductive health services, including contraceptive methods provision, Ethiopia remains challenged with wide gaps and lags in service provision to reach the desired level of contraceptive acceptance, fertility, and accompanying health and empowerment benefits for women.

An important cue to addressing these challenges is that in similar socio-economic, cultural, and environmental contexts, some women appear to adopt modern contraceptives while others did not. This trend occurs in almost every part of the country where the contraceptive services are available (CSA, 2011; USAID & CARE, 2010). Yet, there is little evidence that explains why. The evidence is also elusive regarding how family planning service provision enhances or discourages uptake for the rural population, particularly within the current health services delivery approach using the health extension program. Virtually no research to date has investigated these issues, particularly as perceived by the primary beneficiaries (the rural women).

Albeit with limitations in relation to scope, context, comprehensiveness, and methods, a significant number of studies have been conducted that have presented findings to guide policies, practices, and further research engagements, often focusing on the demographic and health rationales for contraceptive utilization and on the rates of usage. However, research into the issues related to contraceptive utilization benefits such as women's empowerment and ensuring reproductive rights are missing (Seltzer, 2002). To date, there appear to be no published studies on contraceptive utilization benefits from the perspective of the primary beneficiaries (the women), nor how it is valued and internalized by them in order to ensure the sustained use. Additionally, there is dearth of evidence whether the contraceptive services are provided from the human rights perspective as far as the frontline health care providers and service recipients are concerned (Alemu & Asnake, 2007).

Purpose and Significance of the Study

The purpose of this study is to improve the understandings of contraceptive use and benefits as perceived by the women themselves, with the intent to ensure that the process and content of contraceptive programs contribute to women's empowerment, rights, and the betterment of their own and their children's health. In addition, by sharing experiences of current users' perceptions regarding contraceptive benefits, the study aims to contribute to narrowing the gaps between current users and their counterparts - women with unmet needs - thus improving the understanding of factors contributing to sustained contraceptive use. Overall, the study seeks to assist in the reduction of maternal and child morbidity, mortality, and improved quality of life of women and children in Sidama Zone, South Nation and Nationalities and Peoples Region, in Ethiopia by informing the improvement of contraceptive health services provision.

Furthermore, the study contributes to development of empirical evidence regarding the contributions of contraceptive use in women's health and the status of empowerment. I strongly believe that if a given service is perceived as beneficial, the likelihood of sustained use will be high. As has already been indicated above, there has been inadequate investigation of contraceptive benefits with the empowerment and health of women in mind; issues which are part of the larger framework of reproductive and human rights. The findings of this study contribute to filling the knowledge gap of contraceptive benefits from the perspective of women who are primary beneficiaries, and therefore strengthen understanding of what sustains

contraceptive use. The study also paves the way to expand services for those not currently using them and creating links with existing users. More importantly, the findings of the study contribute to the knowledge of affected women regarding contraceptive use in terms of their human and reproductive rights in the context of the health extension program.

In addition to the aforementioned significance, policy makers and services providers will benefit from this study if findings are applied to the design of services from the perspective of contraceptive use being beneficial to the empowerment and reproductive rights of women. Thus, informed reproductive health services provision is then oriented towards a family planning rationale rooted in the human and reproductive rights stipulated in the Cairo Conference of International Population Development. In addition, the findings of this study will enable planners and service providers to identify gaps in providing comprehensive family planning services, increase participation of women, and address the broadest dimensions of contraceptive rationales. The study also builds on the knowledge of the new health service delivery approach the Health Extension Program, and contributes to the expansion of contraception access and the perceptions of women regarding the benefits of contraceptive use; all in a context of women's rights, empowerment, and health status.

Objectives and Questions

Aim of the study. The overall aim of the study is to improve understanding of contraceptive utilization to improve service provision toward empowerment of women in Sidama Zone, South Ethiopia.

Objectives of the study

General objective. To elucidate rural women's perceptions and experiences of contraceptive utilization in Sidama Zone, Ethiopia.

Specific objectives:

1. To describe rural Ethiopian women's perceptions of contraceptive use for maternal and child health.
2. To reveal rural Ethiopian women's perceptions of contraceptive use toward their empowerment (economic, psychological and physical);
3. To describe patterns of contraceptive services provision in the Sidama Zone
4. To capture health care providers perceptions of what enables contraceptive service use

Research questions

1. What are the current patterns of contraceptive use in the Sidama Zone?
2. How do women perceive the contributions of contraceptive utilization towards their empowerment and health?
3. How do health care providers seek to create an enabling environment for contraceptive service use?

CHAPTER 2-LITERATURE REVIEW

Introduction

The study questions and objectives guide the literature review of this study. Hence, the core aspects of the literature review focus on contraceptive utilization and related benefits, and on enabling factors for service provision. This chapter provides detailed information about related conceptual issues, research findings, and identified gaps in the literature. The majority of the literature comes from scholarly journals, international organizations' annual reports, and strategies. Literature reviewed from Ethiopian sources also includes national reproductive policies and strategies related to reproductive health issues. I have further organized the literature in terms of the health benefits, women's and reproductive rights related benefits (empowerment, autonomy and decision-making), and demographic and economic benefits of contraceptive use. With respect to the enabling environments of service provision, the literature relates to process and content of contraceptive service organization. Finally, I have addressed aspects related to access and quality of contraceptive use.

A Brief History of Contraceptive Use

Human beings have been using contraceptives for millennia to regulate fertility (Evans, 2009; Sarna, 2000) due to physical, social, emotional, and economic constraints. Many societies have recognized the challenges related to unregulated fertility, and have attempted to reach harmony between fertility and social-economic conditions (Brundell, 1995; Pomeroy, 1975; Sarna, 2000; Wills, 2000). Before the emergence of modern medicine and advances in contraceptive services, people used traditional methods that ranged from sexual practices to the use of natural synthesis and chemicals (London, 1999; Riddle, 1994; Sarna 2000; Sherfley, 1966; Wills, 2000). For example, ancient Egyptians used chemical contraceptives that included crocodile feces, honey, saltpeter, and acacia fruit. Many of these methods were used in the forms of vaginal suppositories producing lactic acid. Ancient Egyptians also introduced the first oral contraceptives around 1300 B.C., which consisted of emmer fruits (London, 1999). They used this product by putting it in the vagina, and heating and drinking oil, celery, and sweet beer for four mornings (Purlackee, 2012). Early Greeks followed the work of a prominent writer of gynaecologic work, Soranus, who recommended the pomegranate peel. The ancient people in Greece and Egypt (Blough & Blough, 1990) also used coitus interrupts (which means the

withdrawal of man's penis from the vagina before ejaculation) as a contraceptive method (Planned Parenthood Federation of America (PPFA), 2012). Among other places, this method is mentioned in the Old Testament; "Onan knew that the seed should not be his; and it came to pass, when he went in unto his brother's wife, that he spilled it on the ground, lest that he should give seed to his brother" (Old Testament: Genesis 38:9) (London, 1999; Sherfley, 1966).

Barrier methods such as "the condom" were also used during in ancient times. People used barriers from different sources to prevent the passage of sperm to the vagina, such as sheaths fashioned from rubber or animal (tortoise or sheep) intestine. The use of chemicals as spermicide, condoms as barriers, and the old Egyptian oral contraceptives not only served as adequate fertility controls at that time, but paved the way for the development of the modern contraceptives (Patrick, 1995; Planned Parenthood Federation of America (PPFA), 2006; Preus, 1975; Marie Stopes 1999; Wun Li, 2005).

Technological advancement in biomedical sciences since the 19th century has greatly contributed to the emergence of a wide variety of contraceptive methods (Dhont, 2010). Generally, contraceptive methods are categorized as natural or manmade, temporary or permanent, and traditional or modern (Creanga, Gillespie, Karklines, & Tsui, 2010; Mansour, Inki & Gemzell-Danielson, 2010). 'Natural' methods of birth control include breast feeding, basal body temperature measurement, the calendar method, the cervical mucus method, abstinence from sexual intercourse during the fertile time, and coitus interruptus. Manmade or artificial contraceptive methods include temporary methods such as female and male condoms, diaphragms, foam tablets, oral contraceptive pills (OCP), Depo-Provera, surgical implants and IUCD (Bitzer, 2010; Daniels, Mosher & Jones, 2013). Permanent contraceptive methods include voluntary surgical interventions for both men and women; the vasectomy, and tubal ligation, respectively (WHO, 2011). Contraceptive success rates of each method vary, with surgical procedures and modern methods being far more effective than most natural methods.

Benefits and Rationales of Contraceptive Utilization.

The innovative development of safe and effective contraceptive methods has critically benefited humankind in numerous ways (Barot, 2008; Cleland et al., 2006; Lule, Singh & Chowdhury, 2007; Martson & Cleland, 2004). The outcomes of contraceptives include; poverty reduction, reduction of maternal and child mortality, women empowerment by reducing the burden of excess childbearing, and enhancement of environmental sustainability by stabilizing the population of the planet (Ahmed, Li, Liu & Tsui, 2012; Cleland et al, 2006; Olson & Piller, 2013, Rustein, 2008; Stephenson Baschieri, Clements, Hennik & Madise, 2007). Indeed, the cross cutting nature of contraceptives towards Millennium Development Goals (MDGs) has offered a unique opportunity for the world leaders to reaffirm that access to family planning services is essential to reducing poverty and advancing human well-being (Lule, Roman Oman, Epp, Huntington & Rosen, 2005; Morelan & Talbird, 2006; Singh , Darroch, Ashford, & Vlassoff, 2009).

In the last fifty to sixty years, there have been a number of rationales and related benefits advanced by global agencies for the use of contraceptives, which were frequently adopted by national health systems in their own campaigns (Bongaarts et al., 2012; Cleland, 2004; Cleland, 2006; Sinha, 2005; Sonfield , Hasstedt, Kavanaugh, & Anderson, 2013; Tsui et al., 2010).

In this next section, those rationales and related benefits are identified as; demographic and economic benefits, health benefits, women's rights, and reproductive rights. The section on rights is further divided into a brief introduction to gender, empowerment, and human rights.

Demographic and economic rationale/benefits. Some demographers posit that world population growth has passed through three stages: the pre-transition/ pre-industrial, transition, and post transition. In the first stage (pre-transition), for almost all of human history (about 100,000 years), world population growth was negligible. Numbers increased slowly from some 8 million in 8000 BC to 370 million in 1350 AD; by 1750 the population was 800 million, having taken 1600 years to double from 1650 to 1950 (Cole, 1974). The second stage (transition stage/industrial) was rapid and characterized by high fertility and reduced mortality. It took various shapes and lasted for varying amounts of time across the world (Reher, 2004). Some nations are said to be still in the transition phase and others are in post transition. In Europe, the transition took place in the 19th century (Eastwood & Lipton, 2001). Ethiopia is in the second stage of demographic transition, where a steep rise in population is due to longer life-

expectancies and a consistently high birthrate (Montgomery, 2012). The third stage, characterized by declining fertility and low mortality, is not globally uniform across the world and is currently manifested by most of the 'developed world' and in some developing South East Asian and Latin American countries (Askew, Ezeh, Bongaarts & Townsend, 2009; Livi, 2001;Yaukey, 2007).

In 1950, the world's population was 2.6 billion, the average number of children born over a woman's life time (total fertility rate or TFR) was 5.3, and annual population growth was 48 million (UN, 2004, 2005). Since then, the TFR has decreased to 2.4 in 2012, but since death rates have also declined and world population has increased to 7 billion, about 78 million people are now added to the world's population each year (PBR, 2012). Developing countries are projected to account for ninety nine percent of global population growth between 2007 and 2050 (UN, 2004; UN2005).

It took only 12 years, from 1987 to 1999, for world population to grow from 5 billion to 6 billion. This is the shortest recorded time in which 1 billion people, equivalent to the population of India or the combined population of Europe and North America (UN, 2004), have been added to the world total. Though the UN medium variant projection suggests that a decline in TFR worldwide to 2.02 by 2050, the total global population is still projected to increase to 9.2 billion in the same year (UN, 2004).

Despite projected declines in fertility, the annual number of births is expected to remain high (UN, 2003). Previously high fertility levels have left many poor countries with many women of reproductive age, whose numbers are projected to increase from 1.7 to 2.1 billion between 2005 and 2050 (UN, 2003). As these women continue to have children, population size will increase even as fertility rates decline, a phenomenon known as 'population momentum' (Espenshade ,2011). High fertility also persists in much of the world, ensuring that population growth will continue. In 2006, the average family size among the four billion people living in less developed countries outside of China was estimated at 3.4 children, with an annual population growth rate of nearly two percent (Eastwood & Lipton, 2006).

Contrary to what some people may think, future population growth will not primarily be due to the desire for large families. In 1994, Bongaarts estimated that most of the projected population increase in developing countries will result from population momentum (forty nine percent), followed by unwanted pregnancies (thirty three percent), and only lastly desired family

size (eighteen percent) (Munshi & Myaux, 2006). The significance of unwanted pregnancies for population growth can be seen in the high proportion of pregnancies that are unplanned each year: out of 210 million pregnancies worldwide, 80 million (thirty eight percent) are unplanned and 46 million (twenty two percent of all pregnancies) end up in abortion (FMOH, 2007; PRB, 2011).

Rapid population growth has been a concern for demographers, economists, and social scientists as it is believed to cause disharmony in the balance between economic development and natural resources (Bremner et al., 2012; Bryant et al., 2009; Eastwood & Lipton, 2001; Getahun, 2010; Degu & Worku, 2009). Rapid population growth stretches both national and family budgets thin with the increasing numbers of children to be fed and educated and workers to be provided with jobs (Aspen Global Health and Development, 2011; Basten, Herrmann, & Lochinger, 2011). Slower per capita income growth, lack of progress in reducing income inequality, and more poverty are cited as consequences. Women in particular are less likely to join the workforce, and to do so for a shorter period of time (due to high fertility), reducing the productive capacity of the economy (Bloom , Canning, & Sevilla,2003; Schultz, 2005).

If population growth outstrips economic growth, poverty levels may increase (Bremner et al., 2012; Degu & Worku, 2009; Getahun, 2010). The World Bank predicts that Africa will experience positive growth of one point six percent between 2006 and 2015. The World Bank also predicts that, based on current trends, 340 million people in Sub Saharan Africa will still be living in extreme poverty by 2015. This is due to the counteractive effect of large rates of population increase and poverty on rates of economic growth (Sinha, 2003). Investments in health care services, including those related to sexual and reproductive health can make valuable contributions to wider development goals (London FP summit, 2012; World Bank, 2007). For example, family planning allows women to achieve higher levels of education and a better balance between family and work (Ahmed, Li, Liu, & Tsui 2012; Benagiano, 2007; Saha & van Soest, 2013; Sinha, 2003).

In addition, contraceptives can help avert significant economic, social, and psychological costs, especially those arising from a mis-timed or unwanted pregnancy. Besides the medical benefits, some of the economic benefits of contraceptive services in this common scenario have been estimated by calculating subsequent savings on government funded primary and secondary education and health services. In high mortality, high fertility African countries, investing in

family planning save US\$78 in costs related to unintended birth (Ahmed et al., 2012, Cleland et al., 2006; Singh & Darroch, 2009).

Investing in family planning also cuts the cost of social services as, for example, there are fewer children to attend school, and fewer pregnant women seeking antenatal and delivery care. Depending on which social services are offered, each dollar spent on family planning may save governments up to US\$31 in expenditures on health, education, food, housing, water, sewage, and the like (Singh et al., 2004). Slower population growth also places less stress on limited natural resources, including fresh water and arable land (Singh et al., 2004).

Reducing unintended pregnancy is a factor in continued population growth that is amenable to program and policy intervention. Organized family planning programs have a track record of more than 40 years of success in helping hundreds of millions of couples choose the number and timing of their pregnancies (Darroch & Singh, 2011; Tsui, McDonald & Burke, 2010). Consequently, using a demographic rationale, contraceptive use is one of the cost effective solutions to demographic problems as it plays a significant role in harmonizing population growth and economic development through the regulation of fertility rates, thereby lowering pressure on finite natural resources (Singh & Darroch, 2012;; Seltzer, 2002; Vlassoff et al., 2009).

Health rationale/benefits. Maternal and child health programs are together treated as one of the priority health programs in most countries. They are frequently coupled, because mothers and children have closely related health outcomes (Alemayehu, Haider, & Habte, 2009; Lassi et al., 2014; Victora et al., 2008; Minkovitz, Chen & Grason, 2002). They are prioritized because their numbers contribute to about two-thirds of the total population of most nations. It has been realized that high maternal mortality is associated with high pregnancy rates, childbirth complications in older and younger women, and abortion. It is reported that globally, forty one percent of pregnancies are unwanted, with twenty two percent resulting in induced abortion (Gaym, 2009; UNICEF, 2009; WHO 2007).

A health-based rationale for contraceptive use supports the assertion that contraceptives contribute to the improvement of the health of mothers, children, and to the entire family through averting unwanted and unplanned pregnancies and unsafe abortions (Bongaarts et al, 2012; Gibson, Koeing, & Hindin, 2008; Sonfield et al., 2013; Tsui et al., 2010). Having numerous and frequent pregnancies adversely affects the health and wellbeing of mothers and babies, and

overstretches the household workload and national economy (Cleland, Bernstein, Ezech, Faundes, Glasier, & Innis, 2006; Freedman et al. 2005; Gribble & Voss, 2009; Martson & Cleland, 2004; McGinnis, 2011; UN, 2010).

Contraceptive use protects women and infants from the medical risks of pregnancy, delivery, and the postpartum period. In particular, those risks associated with unplanned pregnancies, closely spaced pregnancies, or pregnancies among women who are very young are alleviated (Bongarrts et al., 2012; Rutstein, 2008; Sinha, 2003). A third to two-fifths of maternal deaths could be avoided if unplanned and unwanted pregnancies among sexually active women were prevented through contraceptive use (Martson & Cleland, 2004; Singh et al, 2009; Smith, Ashford, Gribble, & Clifton, 2009).

Studies indicated that globally, about ninety percent of abortion-related and twenty percent of obstetric-related mortalities and morbidities could have been averted by use of effective contraception (Cleland et al., 2006; Freedman Waldman, de Pinho, Wirth, Chowdhury et al., 2005; Peipert, 2012). If countries with high birth rates promote appropriate family planning measures, thirty- two percent of maternal and ten percent of child deaths can be averted (Barot, 2008; International Planned Parenthood Federation (IPPF), 2008; Nelson & Rezvan, 2012). A systematic world-wide study has indicated that for each month fewer than 18 months lapsed between pregnancies, the likelihood of low birth weight increases by three percent, while having a premature birth increases by two percent (Conde-Agudelo , Rosas-Bermúdez, & Kafury-Goeta, 2006). Similarly, the elimination of closely spaced births, defined as those occurring less than two years apart, would prevent about 1 million deaths of children aged under years, out of 11 million such deaths each year (Cleland et al., 2006).

Within the context of Ethiopia, contraceptive service provision was started with the intention of addressing the issue of population growth and economic development, and maternal and children health (USAID, 2010). Evidence indicates that if all unmet needs for family planning were met, 1.5 million unintended pregnancies, and one-third of maternal mortalities could have been averted. Even currently low levels of contraceptive use have contributed to the improvement of maternal health by averting 700,000 unwanted pregnancies and 188,000 induced abortions in a year in Ethiopia. As such, family planning has averted approximately 2,700 maternal deaths and prevented the loss of 240,000 healthy years from women's lives each year (Guttamacher, 2010; United States Aid for International Development (USAID), 2009).

Gender, women's rights and empowerment related rationale/ benefits.

Gender perspectives. Gender is a set of characteristics, roles, and behavior patterns that distinguish women from men socially and culturally, and thereby contributes to relations of power ascribed to gendered identities (Krieger, 2003). These characteristics, roles, behaviour patterns, and power relations are dynamic; they are subject to change among different cultural groups over time because of the constant shifting and variation of cultural and subjective meanings of gender (Hirut, 2004; Roughgarden, 2004). These socially and culturally created differences are not free from creating untoward impacts and have been the source of various outcomes in the socio-cultural and political domains. The effect of gender varies on socially created gender roles and the way in which these roles function (Judge & Livingstone, 2008; UNICEF, 2006).

Gender distinctions are often used to legitimize and perpetuate unequal power relations between women and men. The relation favors men holding the upper hand in social, economic, political, and legal matters, while women are subjected to being devalued in the social and economic realms, and subordinated in legal status (Bielkiewicz, 2011). The socially created power difference between men and women has far reaching consequences. Gender dynamics tend to manifest in various shapes and patterns in relation to the level of development among nations, and produce varying types of socio-developmental effects (Kraft, Wilkins, Morales, Widiono, & Middlestedt, 2014).

The majority of women in the developing nations suffer from social, economic, and political disadvantages (WHO, 2009). Women across the world exhibit low resource ownership as compared to men. This situation is generally worse in the developing nations when compared to the developed nations. The educational status of women is not equal to their male counterparts. There is a significant difference between men and women in this regard as one moves up in the socio-economic and political hierarchies, and the gap is getting wider (UNICEF, 2010). Moreover, women's involvement in the gainful economic sector is limited. Women in developing nations are largely engaged in domestic duties for which they are not paid. If they get a chance to be employed, in most cases, they are employed in low-level jobs, and are frequently paid less than men for the same work (USAID, 2013). These situations perpetuate the poverty cycle and are passed on to following generations.

Power differences between women and men, and the consequential lack of women's decision-making ability on domestic and other issues has created many challenges for women's well-being. Women's lack of power to decide on domestic issues, to mobilize resources, and to move out of their houses to seek services, has hampered them from accessing health services both for themselves and their children (Rottach, Schuler, & Hardee, 2009; UNICEF, 2006; UNICEF, 2010). Women's lack of power to enforce decisions on how to access existing health services, including reproductive health, is one of the major causes for health problems in the developing parts of the world. It is known that developing nations bear huge burdens of preventable mortalities and morbidities (Schuler, Rottach, & Mukiri, 2011).

Cognizant of the situation, the United Nations has developed the Millennium Development Goals (MDG) that seek to reduce the gaps between developed and developing nations, with a focus placed on gender issues. Of the eight development goals, four are directly related to gender issues, while the others contribute indirectly to the attainment of gender parity in the development arena. The eight MDGs are highly interconnected (see annex 7, p. 219), with the attainment of one directly contributing to the attainment of the others (Heyzer, 2005; Kabeer, 2005). In various parts of the world, organized and interconnected efforts to improve reproductive health through pursuing the MGDs have revealed encouraging results. Some nations are well on-track to achieving the MDGs. Most notably are the reduction of gender gaps in primary education access and the correlation between significant reductions maternal and child mortality rates. Though the global efforts toward achieving the MDGs and the closing gender gaps is encouraging, there remain huge variations across nations relating to corresponding levels of development and political leadership and commitment (Chen & Ravillion, 2012; World Bank, 2011).

Gender in Ethiopia. Ethiopia, one of the least developed countries of the world, is characterized by low status for women. Ethiopia ranks 127 out of 142 countries in the Gender Gap Index, which serves to indicate statures of global gender equality (World Economic Forum, 2014). Lack of access to productive resources such as land; lack of access to education and employment opportunities; lack of basic health services; lack of protection of basic human rights; low decision making power; prevalent domestic violence and harmful traditional practices are but some of the indicators of the socioeconomic marginalization of women in the country

(Hirut, 2004; Mukuria, Aboulfia & Themme, 2005; Yegomawork, Emebet, Hirut & Yemane, 2005).

This gender gap between men and women in terms of socio-economic indicators has a negative impact on the overall development of the country and on the demographic and health outcomes of individuals. According to Kishor (2005), gender differences in power, roles, and rights affect health, fertility control, survival, and nutrition through women's access to health care, lower control over their bodies and sexuality, and restrictions in material and non-material resources.

Women's lack of choice in domestic affairs further hampers their capacity to access services in Ethiopia. Studies indicate that only fifteen percent of currently married Ethiopian women make their own choices on their own health care. Nationwide only forty- four percent participated in all four types of identified decisions (those pertaining to their own health care, those regarding big purchases, those regarding daily purchases, and those about visiting families), while eight percent of women did not participate in any of these decisions at all (Bloom & Wypij, 2000; Mekonnen & Asrese, 2014). Despite highly encouraging efforts to close gender gaps (World Bank, 2007), Ethiopia has far to go to reach the desired level of gender parity in all aspects of development and human affairs (World Economic Forum, 2014).

Women's rights/human rights rationale. Human rights are based on the principle of respect for the individual. Their fundamental assumption is that each person is a moral and rational being who deserves to be treated with dignity. They are called human rights because they are universal. Whereas nations or specialized groups enjoy specific rights that apply only to them, human rights are the rights to which everyone is entitled—no matter who they are or where they live—simply because they are alive (Oxford Dictionary of Law, 2009; UN, 1948). Thus, women's rights are part of human rights in all matters described as applied to women (Cottingham, Germain, & Hunt, 2012).

Sexual and reproductive rights are inalienable human rights, inseparable from other basic rights such as the right to food, housing, health, security, education, and political participation (Shalev, 2000). Sexual and reproductive rights can be defined in terms of power and resources: the power to make informed decisions over one's own fertility, procreation and child care, gynecological health and sexual activity, as well as the resources to carry out those decisions safely and effectively (Correa & Petchesky, 1994).

Women comprise a significant portion of every society, (Irwin et al, 2006) constituting nearly fifty percent of the global human population, varying in proportion with age (UN 2009; UN 2010). Women have numerous roles in a society ranging from the household to the community, as well as in national and international arenas. These roles are categorized in diverse ways according to the society's underlying ideology, socio-economic status, cultural, and religious conditions (Beaman Chattopadhyay, Duflo, Pande, Topalova, 2009; UN, 2010). The status of women in the world is a far-reaching topic that covers issues such as girls' education, women's roles within the family, community, and politics, maternal health, economic empowerment, and many more (Ogato, 2013).

Empowerment is the process by which the powerless gain greater control over the circumstances of their lives (Batliwalla, 1994; Oronje, Crichton, Theobald, Lithon & Ibisomi, 2011; Naryana, 2002; Sen & Batilwala, 2000). In more elaborative description, empowerment is the enhancement of assets and capabilities of diverse individuals and groups to engage, influence, and hold accountable the institutions that affect them (Singh & Gupta, 2013; ICRW, 2011). This includes control over resources (physical, human, intellectual, financial) and over ideology (beliefs, values, and attitudes). Empowerment thus can be seen as both the process and outcome attained through intrinsic and extrinsic involvements. The motivation and ability to choose is intrinsic to the inception and sustainability of women's empowerment. Extrinsically necessary forces for the empowerment of women are the creation of an environment which enables, facilitates, and encourages that empowerment through policy and political forces, community organizations, and familial institutions (Batliwala, 1994; Malhotra, Schuler, & Boender, 2002).

Decades of data have demonstrated that when the status of women improves, the quality of life improves for everyone (Tebekaw, 2011; World Savvy, 2009; Zaid & Popoola, 2010). Women's status also varies from between and within nations (UN, 2014). In almost all patriarchal societies, women receive subordinate roles in almost all spheres of life (Gita, 2000). This subordination situates them in a marginalised sphere of life that includes difficulty to control their reproductive and sexual affairs. In most developing countries, the status of women is often that of poor, powerless, and pregnant (Ogato, 2013; UNFPA, 2008). For example, women and girls carry a disproportionate amount of the burdens of poverty (seventy percent) and

make up two-thirds of the world's illiteracy rate (Lopez-Carlos, 2005; UN, 2009; UNISCO, 2005).

The link. The link between reproductive rights and women's empowerment and the role of contraceptive utilization is obvious (Bongaarts, 2014). The ability of women to control their sexuality and fertility through proper use of contraceptives is the cornerstone to ensuring other aspects of women's and human rights (Barroso, 2010; Fantahun, 2006). Contraception offers remarkable contributions towards the empowerment of women in multiple ways, including the avoidance of unplanned and unwanted pregnancies, increasing the amount of time between successive pregnancies, and enabling engagement in educational and economically gainful activities (Cleland, 2004; Cleland, 2006).

As previously mentioned, the demographic rationale of contraceptive use has taken precedence over other aspects and benefits, including that of women's rights. In the early 1940s and 1950s, the discussion on contraceptive use was centered on overpopulation, until the 1970s and 1980s, when the emphasis shifted to that of health specifically on the reduction of maternal and child mortalities and morbidities. Although women's rights in relation to contraceptive use have been invoked since as early as 1910, this rationale remained obscured by a lack of public attention. Strong global women's movements rising against the overemphasis of overpopulation on the issue of contraceptive services have made remarkable progress over the past two decades in re-situating contraceptive provision as part of the broader issue of women's rights and desires (Alexander & Wetzel, 2011; CookDickens, & Fatalla 2003; UN, 1995). These movements assert that any policy and program geared towards contraceptive services provision should consider the social justice and individual rights involved in every aspect, and in all social and economic situations (Jacobson, 2000; Hardee, Eggleston, Wong, Irwanto, & Hull, 2014).

Moreover, persistent women's rights advocacy and movements have played great roles in making visible the benefits contraceptive use from a women's rights perspective (Gupta, 2000). The unprecedented efforts of such movements have led to a reinvigoration of the women's rights issue as a central aspect in development, as is clearly stipulated under the International Conference of Population Development (ICPD) agenda in Cairo in 1994.

The human rights rationale for contraceptive use is related to feminist framings that assert it is every woman's right to control her reproduction. Within the Feminist frameworks, control over one's reproductive right is not only a human right, but also increases women's potential

access to participation in other spheres of life (Kaler, 2000). The rationale of human rights, and indirectly, the framework of Feminism, encompasses the reproductive rights of both women and men. Reproductive rights are fundamental human rights; ensuring these rights for female-male couples or individual women contributes to the highest possible level of reproductive health outcomes (Chaya, 2007; Dugassa, 2005; UNFPA, 2010), and the possibility of improved status for women. Moreover, a Feminist framework consolidates reproductive rights as part of human rights; ensuring that women's potential to improve all spheres of their lives is improved by controlling their reproduction (UNFPA, 1997).

The ICPD Program of Action stated that the conference sought to address “the growing recognition of global population, environment and development interdependence” and establish “policies to promote sustainable economic growth in the context of sustainable development in all nations.” In line with this, the ICPD stressed that women's empowerment was one of the strategies identified as critical to addressing the population and development problems identified and in achieving the proposed goals (UNFPA, 2008). The program articulated the issue as “the empowerment and autonomy of women and improvement of their political, social, economic and health status is a highly important ends itself and a means to achieve for sustainable development” as cited in Jejeebhoy, 1995, PP. 275-295.

Since the release of the ICPD, the issue of contraceptive provision has recognized women's rights as reproductive rights, and as being included in all reproductive health components, including family planning. These relationships were clearly stated under the definition of reproductive health provided by UNFPA, indicating that:

“a state of complete physical, mental and social well-being and..., not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-

care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant” (UNFPA, 2008, para. 72).

The past four decades of policy development and public discussion have in one way or another produced some degree of benefit towards the empowerment of women and women’s rights. Studies have confirmed that contraceptive use improves the livelihood and status of women through various means. A longitudinal study in Matlab, Bangladesh has indicated that a family planning program contributed to a 15 percent decline in fertility, thereby improving the health and status of the women in the study, their involvement in productive activities, and the access of their children to increased rates of schooling (Conde-Agudelo, Rosas-Bewrmudez, & Kafury Goeta, 2007; Joshi & Schultz, 2005).

A study in Bolivia by Joshi and Schultz, (2005) showed that women with fewer children had a better chance of engaging in paid work. Contraceptive use was associated with working outside the home in paid work, and was correlated to the growing number of women joining the Bolivian labour force. A similar study carried out in the six western African nations also showed that contraceptive use significantly contributed to the reduction of poverty and improved rates of access to schooling (Wasu, 2011). Another study in Sub-Saharan Africa revealed that contraceptive use has increased the likelihood of children being able to attend school (PRB, 2011; World Bank, 2011). Previously recorded consecutive birth intervals consisting of less than two years had been associated with an approximately fifteen percent decline in the probability of primary school enrollment for both girls and boys (Longwe & Smits, 2012).

In Ethiopia, a significant amount of research was conducted in relation to contraceptive use. Few of these studies addressed the benefits of contraceptive use related to demographics and health benefits. There is a dearth of information with regard to the benefits of contraceptive use from the perspectives of women’s rights and empowerment. The government of Ethiopia has realized the importance of providing family planning from the perspective of human/women’s rights and designed a new family planning strategy emphasizing these rights and has incorporated similar considerations in the health extension program (FMOH, 2005). This study has investigated the lived experiences of Ethiopian women using contraceptive, and the benefits they have gained from these services.

Enabling Conditions for Contraceptive Service Provision and Utilization

The use of available health services is commonly affected by accessibility, availability, and quality of the service in a given setup (Ensor & Cooper, 2004). Accessibility to contraceptive service in turn influences service utilization in various ways (Pacque-Margolis & Pucket, 2013; UN, 2013). Service is said to be accessible when it accommodates physical, financial, and socio-cultural perspectives (Chaya, 2007). Physical accessibility brings service closer by averting barriers such as distance and other geographical bottlenecks. When a service is situated far away from those who need it, people cannot easily get the service, and thus are denied access. For almost all segments of society, the rural sector in particular, the loss of time associated with travelling such distances also has an impact on service access. Bringing services physically closer to the potential users is crucial to access and actual service use (Dynes, Buffington, Carpenter, Hardley, Kelly, & Tadesse et al., 2013; Freedman, Waldman, Pinho Wirth Chowdhury & Rosenfield, 2005; Hoke -Long, Whittaker, & Herceg-Baron, 2012).

Another issue that affects service accessibility is the financial aspect (HIPs, 2013). Health services by their very nature are not cheap. The complex interplay between technology and high level professionals make health service costly (Macha, Harris, Garshong, Ataguba, Akazili, Kuwawenaruwa & Borghi, 2012). Out-of-pocket payment acts as one of the challenges facing health services access in Ethiopia. For resource-limited nations or individuals, the capacity to pay for service is not simple (Creanga et al., 2011; Jacobstein, 2013). Therefore, to ensure financial access to health services, functional strategies that facilitate service accessibility should be in place by removing barriers (HIPs, 2013; Singh & Darroch, 2012).

Acceptance of health service is another crucial area that plays a key role in ensuring health service utilization (MSH, 2011; Prata, Gessesew, Cartwright & Fraser, 2011). In order to improve health service acceptance, health service organizations should pay attention to the socio-cultural aspects of the society (Solar & Irvin, 2007). Health service is well accepted when the service delivery approaches match the desires of service users. The attitude and behavior of health professionals should be congruent with the society's culture, values, and norms in order to motivate them to use the services. The favorable attitudes of health professionals, their competence, knowledge, and skills, together with the way they communicate to patients, can clearly influence service use (Obrist, Iteba, Iengler, Makemba, & Mshana, 2007; Provincial Health Authority, 2011).

Similarly, contraceptive services are affected by many factors. These can be expressed in terms of service organization, content, and processes in light of accessibility, availability, and quality. Historical trends in the provision of contraceptive service indicate that contraceptive service in developing nations began with a strong push from the developed nations around the 1960s (Bongaarts & Sinding, 2009; Cleland, 2008; Seltzer, 2002; McLaren, 1990). Lack of strong government commitment of some developing nations in the past, along with resource limitation together and underlying socio-cultural factors remain major impediments for the expansion of the services in these nations (Harkavy & Roy, 2007). Most notably, contraceptive service access is affected by the availability of adequately organized institutions both in terms of available health professionals and the material inputs required to run the services (Westoff & Cross, 2006).

Globally, various approaches have been used to reduce the barriers impeding health services delivery, including contraceptive services (Hock-Long et al, 2012; WickstromYanulis, van Lith, & Jones, 2013; WHO, 2012). Countries collectively or individually designed strategies to harmonize health services deliveries. Modalities such as institutional and communities-based approaches are among many that have been in place for the last few years (Gruskin Mills, & Tarantola, 2007). The declaration of primary health care is one of the important land-marks in improving access to health services in developing nations. Primary health care has been a breakthrough in extending health services to community and household levels by engaging community members in their health affairs. It has not only paved ways to extend health service to people but also indicated a means to offer health services from human rights perspectives (Cueto, 2004; WHO, 1978).

Primary health care declaration revealed clear directions and components of health services that nations could give priority based on their level of development and other underlying circumstances (Haggerty, 2007; Health Council of Canada, 2005). During its initial stage, PHC has encompassed eight components out of which family planning/contraceptive service was situated under the maternal and child health component. It has come into the picture with the outstanding health rationale of reducing maternal and child morbidities and mortalities in the developing nations (WHO, 1978). Many developing countries have made primary health care a leading and fundamental aspect of their health care delivery systems. In addition to the

institutional health service delivery, a community-based service delivery has received special attention during this time (Perry, Zulliger & Roger, 2014).

In developing countries, contraceptive services are not evenly distributed across the nations, and significant variation is documented within nations (Mbizvo & Phillips, 2014). Diversities in geographic locations, economic status, culture, and underlying traditions collectively contribute to the variation in service access (Levesque, Jean-Frederic., Harris, & Russel, 2013). Variation in contraceptive service patterns have been well documented across the world nations on a regional basis as well as across various states or provinces (UN, 2009; WHO, 2011). Contraceptive prevalence rates vary from three percent in one of the Sub-Saharan countries in Africa, to eighty eight percent in the country of Norway, which is considered to be developed (PRB, 2011). Africa is known for its low contraceptive use pattern, measured by a low contraceptive prevalence rate and high unmet needs for contraception (PRB, 2011; WHO, 2011). Sub-Saharan African nations disproportionately contribute to the lowest global levels of contraceptive prevalence rates (twenty- one percent) and high unmet need for family planning (twenty five percent) (PRB, 2013; WHO, 2011).

Ethiopia, despite its tremendous efforts to improve the low level of contraceptive use, has a long way to go until it reaches the global average. History indicates that contraceptive services have been present in Ethiopia for the past half a century. Service provision was advocated by a small group of volunteer professionals from the health and social sciences (FGAE, 2000; Olson & Piller, 2013; UNFPA, 2012). Lack of knowledge, prevailing patriarchal attitudes, and conservative cultural, religious, and government organizations were strong influences that have hindered the expansion of services to various parts of the country. Moreover, lack of clear health and social sector policies and the long stood civil war were obstacles to the smooth service expansion (Ahmed & Mengistu, 2002; FGAE, 2000).

Since the overthrow of the military *dergue* government by military action, the current government appeared with new health and population policies after critically evaluating the drawbacks of the former health delivery approaches. Both the health and population policies have been given adequate attention to the decentralization, equity, and popular participation in issues pertaining to health and the demographic aspects of societal development (TGE, 1993). Ethiopia has recognized that health issues need the involvement of multiple sectors and collective undertakings. Therefore, the country clearly revitalized the primary health care

approach through identifying key stakeholders and sectors to be involved in the execution of health related actions (FMOFED, 2005; TGE, 1993).

The Ethiopian Ministry of Health (MOH) has taken numerous actions to improve the health of Ethiopian populations since the development of new health policy. Among the major steps the Ministry has taken is the development of a twenty year health sector development plan (HSDP) that is comprised of five, five-year phases. As steps toward the implementation of reproductive health, MOH has also developed a reproductive health strategy that gives clear directives and attentions to the provision of contraceptive services as one of the core components of the reproductive health programs. Family planning is indicated as one of the six priority areas in the reproductive health components (FMOH, 2006; FMOH, 2009).

Along with these initiatives, Ethiopia has taken great measure to decentralize the health management system to the district level for the first time in its history in 1993. This approach has created modest improvement in expanding access of health services to various parts of the nation (Eva Ngo, 2010; HPN & the World Bank, 2009; Wamai, 2007). However, the progress has been sluggish for almost all health services to reach to the majority of the hard-to-reach rural population (about 84% of the population of the country resides in rural areas). After critical evaluation of the health-based initiatives previously listed, the MOH revised its approach and incorporated community-based health service delivery in 2003 (Argaw 2007; Center for Health and Gender Equity, 2010; Teklehaimanot, 2013).

The Health Extension Program (HEP) is not only an innovative approach but is a paradigm shift in Ethiopia's health service delivery that has created strong links between the mainstream institutional health service and community-based health service expansion (Health system 20/20 USAID, 2012). The special nature of the health extension program is that the actors or service providers are women enrolled from the rural *kebele* where they originally resided, and secondly, they are permanent employees of the government, unlike the former completely volunteer base. The selected women go through nine months to one year of training designed to enable the provision of the health extension packages (FMOH, 2006). Moreover, the HEP is expected to improve access through improved availability and acceptance as the workers largely share similar cultural backgrounds and speak the same language as the community they serve (FMOH, 2006; FMOH, 2008; USAID, 2014).

Physical service coverage in terms of contraceptive availability has reached above ninety percent through its new innovative community-based health extension program (Teklehaimanot & Teklehaimanot, 2013). Almost all rural *kebele* (the smallest unit of administration) have one health post with corresponding two or more health extension workers. The health extension workers provide contraceptive related information and services (FMOH, 2008). The rural health extension program has covered almost all catchments in the nation. Based on lessons learned from the success of the rural health extension program, the urban health extension was established to link community health and health institutions. The government deployed nurses to serve as community health workers with the aim of improving access to and equity of public health information and services (USAID, 2014).

Contraceptive service is one of the sixteen health packages in the health extension program. The method mix improved over time. At its initial stage, the health extension worker provided health information and oral contraceptive pills only. After some time, the government introduced the injection method through the health extension program. Based on the success of the provision of oral and injection-based methods and the need to increase options for service users, the government in consultation with its partner organizations introduced contraceptive implants at the health posts. The health extension workers received implant insertion training and started offering implants in 2009 (FOMH, 2010; UNFPA, 2012; USAID, 2014).

As a result, contraceptive service access and availability in Ethiopia rural health posts has grown from a single method to four: condom, pill, injection and implant. Other methods such as loop and permanent methods are arranged in nearby health centers and hospitals by referral services (FMOH, 2010; Kassie, Duga, & Adem, 2014). Studies indicate that contraceptive service access and use have improved in Ethiopia both in contraceptive prevalence and method mixes after the commencement of the health extension program (Prata et al., 2011).

Henceforth, contraceptive prevalence in Ethiopia has greatly improved (more than doubled) in five years' time, from fifteen percent in 2005 to twenty nine percent in 2011. One of the interesting aspects of this improvement is that it comes largely from the rural community. Unlike the previously slow service adoption, as of the time of the HEP, the contraceptive prevalence rate in rural Ethiopia has grown from eleven percent in 2005 to twenty three percent in 2011, attributed to the HEP (CSA, 2011). Study indicates that HEP not only improved the contraceptive prevalence rate but also clients' satisfaction. This is evidenced by sixty- seven

percent of study participants confirming that they were satisfied with the contraceptive services offered by the health extension workers (USAID, 2012).

Quality of contraceptive services. Despite a long duration of adoption, proven means, and established benefits of contraceptive service, the service utilization lacks uniformity across the world nations (PRB, 2008; Ross & Smith, 2011). This situation is evidenced by variations in service use and coverage. Global differences in contraceptive prevalence rates ranges from three percent to eighty eight percent depending on their level of development and underlying socio-demographic and cultural perspectives (PRB, 2011). These differences are not only indicated by the mere measurement of contraceptive prevalence but also by other related indicators such as total fertility rates, and maternal and child mortalities and morbidities (Jain & Ross, 2012; WHO, 2010). For instance, those nations with higher contraceptive use experience lower total fertility rates and a more balanced population growth to one's socio-economic status. Moreover, those nations with better service use have better maternal and children health outcomes (WHO, 2010).

One of the factors affecting contraceptive adoption and sustained utilization is the quality of service offered to patients in various capacities, at the health institution, the community, and household levels (Fantahun, 2005; Kebede, 2007; Okech et al., 2011). When clients' perceive that the service given has met their expectations, the likelihood of their using services for a prolonged time is high; the opposite is also true for use discontinuation (Moreau, Cleland, & Trussell, 2007; PRB, 2002; Tafese, Wolde & Megerssa, 2013). In addition, expansion of services to other clients and sites will remain a great challenge if users perceive the service to be of poor quality or below their expectations (Williamson, Parkes, Wight, Petticrew, & Hart, 2009).

Quality of contraceptive service is commonly seen from the framework developed by Bruce in 1990. Bruce provides a framework for assessing contraceptive service quality as seen from the client's perspective, consisting of six parts: 1) choice of methods; 2) information given to clients; 3) technical competence; 4) interpersonal relations; 5) follow-up and continuity mechanisms; and 6) the appropriate constellation of services. Bruce (1990) and Jain (1989) explain how these six criteria contribute to the quality framework in terms of how each component serves the attainment of sustained contraceptive use and helps individuals and couples reach their desired level of fertility.

The choice of contraceptive methods is a dynamic issue, subject to change in accordance with fertility goals, health status, and age factors, among others (WangWang, Pullum, & Ametepi, 2012). Therefore, enabling clients to have a wide range of contraceptive options to choose from is a fundamental element to ensuring contraceptive service quality (Rose & Stover, 2013). Another dimension of contraceptive service quality is the credibility and comprehensiveness of information given to the clients. Proper method choice and sustained use is contingent on the information clients receive from service providers. Service providers who offer adequate and comprehensive information about the available methods and mechanisms, explaining how they work and what side effects they produce, enable clients to make an informed decision and properly exploit existing health services (Bruce, 1990; USAID-Deliver, 2013).

Studies indicate that the interaction between service providers and clients is probably the most crucial component of effective service delivery because of its effect on clients' family planning behavior and satisfaction (Gulzar & Ali, 2008). "The 'client-provider interaction' (CPI) encompasses both the *process* (how clients are treated and whether they actively participate) and the *content* (what they are told or not told, technical competence, accuracy of information, provision of essential information) of a consultation" (Becker, Koeing, Kim, Cardona & Sonenstein, 2007, P. 206). When client-provider interaction is poor, it ultimately leads to an inadequacy of essential information for clients' to choose an appropriate method; inability to get the method they want; failure to learn what they need to know about using the method or how to cope with side effects; unawareness about which method they can switch to if their current one is unsatisfactory; and or not being satisfied with their method (Jain, RamoRao, Kim & Costello, 2012). The cumulative effect is a failure to achieve their fertility goals due to contraceptive failure or discontinuation (Hong Montana, & Mishra, 2006; Nakhaee & Mirahmadzadeh, 2005).

Conclusion

The preceding review of the literature review has scanned global, regional, and local contexts related to the study topic. It has revealed varying levels of contraceptive service related to use and outcomes across the world. Contraceptive service use varies among nations depending on socio-economic, cultural, demographic and political conditions. The literature

review demonstrates that the status of women is crucial to the enhancement or hindrance of service use.

In developing nations like Ethiopia, many factors contribute to the low level of contraceptive service use. Contraceptive service organization, process and content, and the availability, accessibility, and acceptability of these services are fundamental to improving service utilization. The literature review has indicated that when service is accessible and acceptable to women, the potential for services to be used is increased. Women's perceptions and ability to choose how to use contraceptive services are favourably linked to increases in service use. Thus, the literature review has revealed gaps that exist in regard to the Ethiopian context. The country has low contraceptive service use, although remarkable improvements are underway.

CHAPTER 3-METHODOLOGY

Brief Introduction

The methodology section of the study is organized in such a way that it reveals the overall study organization, the theoretical approach, the design, the way the methods were used to gather and analyze data, quality assurance issues and ethical concerns. I begin with a brief epistemological foundation for the study followed by theoretical approach and conceptual frameworks. The theoretical approach and conceptual framework provided the mental mapping to guide the study processes. Following the research design is information provided about how the study data were gathered, organized, and analyzed. This study has utilized a mixed method approach with major focus on the qualitative method. Quality assurance and ethical issues are then outlined before ending with a discussion of the scope, limitations, and delimitations of the study.

Theoretical Approach

Knowledge generation through its development history, requires guiding foundation (McEwen, 2011, p. 6). From the epistemological perspectives of knowledge development, there are two dominant world views; the received view and the perceived view (Miller, 2014). In congruence with perceived world view epistemological stances, I argue that reality should be explored and constructed from multiple perspectives. Most importantly, knowledge generation should consider the existence of power differences and how this difference can manipulate the outcome. Hence, for this study I chose to broadly use a feminist theoretical approach to assist me in exploring contraceptive use benefits towards women's health and empowerment and to underscore the importance of starting from women's perspectives. To generate robust information and contextualize the information provided, background quantitative information was used to describe patterns of contraceptive use, (Morgan, 2007).

The rationales for choosing a feminist theoretical approach to this study are several. First, as noted earlier, there is a pragmatic concern: the history of rationales used in promoting and executing contraceptive programs suggests that the feminist theoretical approach is the most comprehensive lens for understanding the issues affecting contraception and for effective program implementation. Secondly, a feminist approach makes women's voices central to the analysis. Third, a feminist approach envisions the multidimensional mechanism to increase and

protect women's rights in general and reproductive rights in particular. Moreover, it embraces the importance of personal autonomy and privacy in the reproductive arena by reinvigorating a woman's right to decide on her reproduction and sexuality. Above all, feminist theory argues that a woman has unconditional rights over her own body (Eitzen & Baca-Zinn, 1998; Yuill, 2012).

From the feminist ontological and epistemological discourse, women are the '*knower*', the experts of their lives, out of which knowledge can be produced (Ramazanoglu & Holland, 2002, p. 71; Wylie, 2012). Thus studies that examine how the benefits of contraceptive use are perceived should consider the feminist outlook to ensure that women's perceptions of the service contribute to the reproductive rights of women, their level of empowerment and their emancipation from suppression in these areas (Long & Dunphy, 2012).

Despite the biological privileges of reproduction endowed to women, women in developing nations are disproportionately affected by health problems in general and reproductive health related ones in particular, due to the multidimensional nature of health outcomes. Multidimensionality recognizes that a population's health is affected by a series of factors ranging from individual biological, socio-economic, cultural, behavioral, and economical among others (Kinding & Stodart, 2003; Kuhns & McEwen, 2011; Raphael & Bryant, 2006).

Gender difference and the subordination of women have erroneously been viewed as inevitable natural circumstance by traditional societies. However, gender is a socially constructed phenomenon that is produced and replicated in ways that frequently subordinate and exploit women, though it does so differently in each society. Gender discrepancies and inequalities in any given society affect the status of women in many dimensions, and manifest in myriad ways such as limiting the power of decision-making in either the family or community. The beliefs and societal structures supporting the inferior position of women subsequently influence their capacity to choose on issues related to their health, household income, and freedom of movement (Eitzen & Baca-Zinn, 1998). A feminist theoretical perspective stems from the understanding that gender difference in a given society is not based on a natural or biological difference between women and men but is a socially created phenomenon that can change over time. Feminist theories clearly reveal not only the existence of power imbalances between men and women but also how and why this difference was created (Kruger, Fisher, & Wright, 2014; Oppenheim, 2005).

Based on feminist theoretical assertions, I argue that gender disparity and women's subordination needs to be understood and addressed in the following manners. As a significant part of the society, women deserve equal opportunity in all socio-economic, cultural, and political matters, family structure, and all other human aspects despite biological differences of sex. In order to ensure this, women's experiences should be given attention and considered invaluable in leading to a new world outlook. It is also recognized that gender as a basic organizing concept is not neutral. Rather gendering, as a process, establishes certain underlying assumptions about the positions of men and women (favouring men with power and devaluing women) (Crump, Logan, & McIlory, 2007; Lahey, 2010).

Similarly, gender distinctions are exercised daily in constructing and reconstructing the difference between women and men. Thus, analysis of gender issues must take place within specific socio-cultural and historic contexts that reveal the actual condition of women therein (Martin, Vieraitis, & Britto, 2006; Osmond & Thorne, 1993). It is clear that the differences between women and men affect the multidimensional domains of women's lives, limiting their potential to use contraceptive methods and to be held back from the benefits of the services (Hameed Azmat, Ali, Sheikh & Abas, 2014).

African / Ethiopian feminism application to the study. Global diversities in social, cultural, economic and religious spheres have created difficulties in using a 'one size fits all' approach to feminism. As a result, African feminists have sought to establish feminist approaches which would fit the multiple contexts of the continent (Delmar, 2005). African feminism is the result of the critical evaluation of the impact of the former and current global and local situations. It is shaped by the recognition of the importance of women's inclusion in all spheres of life and recognizes the impossibility of attaining desired and sustained levels of development and peace in Africa without the full involvement of women in all matters and at all levels of decision making (Fayemi, 2004). African feminism is a feminist epistemology and a form of rhetoric that has provided arguments which validate the experience of women of Africa and of African origin, both complementary and in opposition to mainstream feminist discourse (Biseswar, 2008).

Importantly, while many countries in the African continent might have a shared history, they do not have a shared feminist discourse (Tong, 2009). Even the anti-colonial movement, one of the great backbones of the African independence movements, did not have identical

patterns across Africa. For example, Ethiopia is a country which was never colonized except the five year battle base occupancy, and thus it has different experiences related to colonialism and feminist development (Biseswar, 2008). African feminism is useful to accommodate diverse women's contexts and the need to establish proper global links (Leeson, 2004). Many women also stress that the issues advanced by Western feminism are not issues of priority on the continent, citing their own areas of concern, which are often in direct contradiction to what Western feminism stands for. The women's movement in the African continent reflects the gendered cultural, social, and political organization of the numerous African societies in which they are located. African women have long been organized around lineage and kinship groupings, and around women's religious, cultural, and political duties and their productive and reproductive roles (Adawo, Gikonyo, Kudu, & Mutoro, 2011).

The history of African feminism has exhibited some successes. The emergence of multi-party politics has expanded the political spaces available to feminists in Africa, encouraging a variety of organizations to become active in building local, regional, and international networks linked to transnational organizations such as the United Nations. In countries such as South Africa, the strides made by women in public life, political representation, and activism indicate the influence of global and regional feminist movements in advancing the agenda of women of varying political, ideological, and social stripes. More recently, Rwandan women have used the post-conflict phase to mobilise for peace-building and to advance women's political, social, and economic power. Rwanda is now the country in the world with the highest proportion of women in parliament (Tripp, 2005; Wanyeki, 2005). These are clear signs of a need for feminist modalities that suit the peculiar nature of the continent.

Consequently, different modalities of feminism are appearing such as state feminism, party feminism, or elite feminism in some African countries. However, each of these feminist modalities carries its own ideological outlook; it is challenging to achieve the desired level of strength and unity. For example, a political party affiliated with feminism focused on advancing women's interests through the political arena, drawing on women who were linked to political parties bent on capturing state power (Essof, 2005). Mekgwe (2008) argued that such a strand of feminism – born of women's participation in the liberation struggles of Algeria, Guinea-Bissau, Mozambique, Zimbabwe, Angola, Namibia, and South Africa, among many other countries – was strengthened by the post-conflict marginalization of women and poor war veterans, most of

whom found themselves excluded from post-colonial armies, employment, and the economy because of their poor education and lack of links to the liberation elites. Still, it is encouraging to note that there are emerging and progressive feminist discourses on the continent; only time will prove their strengths and weaknesses (Mekgwe, 2008; Simon & Obeter, 2013).

In the Ethiopian context, feminism and feminist theory is not well developed and in most instances not even known (White, 2012). It is also difficult to get adequate and well-articulated evidence of a women's movement in Ethiopia, but some sporadic evidence indicates that it goes back to the 1970s students' movement (White, 2012). The involvement of governments in the Ethiopian women's movement was tremendous and easily shaped to fit the desire of the government. Recently there is a mainstream government-based approach to taking care of matters related to women (Newton, 2007). The Women's League under the ruling party is another organization to be mentioned. The women lawyers' movement was one of the more remarkable movements in addressing the issue of women but, is not currently functional (Biseswar, 2008).

I chose the African feminist approach to frame this study; the reason being that the African feminist approach better recognizes the prevailing contextual factors of African women. Reproductive health problems in Ethiopia are many and deeply embedded in the underlying poverty, patriarchal dominance, cultural and religious influence, harmful traditional practices, and the low status of women. Therefore, to gain insight into those problems, and to raise the status of women and liberate them from the unjust and unfair burdens of reproductive health problems, an African feminist approach was appropriate. Such an approach accommodates the cultural variations, ethnic and linguistic diversity, and the socio-economic differences inherent to Ethiopia. Ethiopia is a country with more than 80 linguistically and ethnically varied people. The country is also known for its geographical and ecological diversity. Together with the feminist theory, the multidimensional nature of contraceptive service use patterns is addressed with a conceptual framework developed by the Women Study Project (WSP), FHI,-360.

Conceptual Framework

As mentioned earlier, the rationale for contraceptive utilization comes from three different sets of arguments related to demographic, health, and rights concerns (Cleland et al., 2006; Eastwood & Lipton, 2001; Freedman et al., 2005; Martson & Cleland, 2004; Seltzer, 2002). This study principally considers reproductive health issues through a rights perspective,

and thus draws on the understanding of reproductive health problems provided by feminist theory (Jacobson, 2000; Kaler, 2000; Kuhns & McEwen, 2011). I used an African feminist theoretical lens to help contextualize the multiple factors within local contexts. The study is further aided and organized with a complementary conceptual framework provided by the Family Health International-Women Study Project (FHI-WSP) (Fig 5). The framework proposes relationships between contraceptive use and multiple domains of women's lives, in a context where external factors can affect both. This framework acted as a road map for developing study guide instruments, analysis, and interpretation of the finding from the broad dimensions.

The WSP conceptual framework, shown in Figure 2 below, has four main clusters of variables. Within the large box, two clusters of variables focus on the woman herself. One cluster contains the variables on family planning provision and use and women's experiences with pregnancy and childbearing. The other focuses on three domains of women's lives: the individual domain, the household and family sphere, and societal and economic roles. These two clusters are influenced by two sets of societal factors and another set of individual factors. Societal factors include the social, political, and economic context in which a woman lives and the gender norms that shape her life. Finally, a woman's life cycle stage and other socio-demographic characteristics shape her family planning use, her childbearing experience and the three domains of her life (individual, family and community (FHI-360).

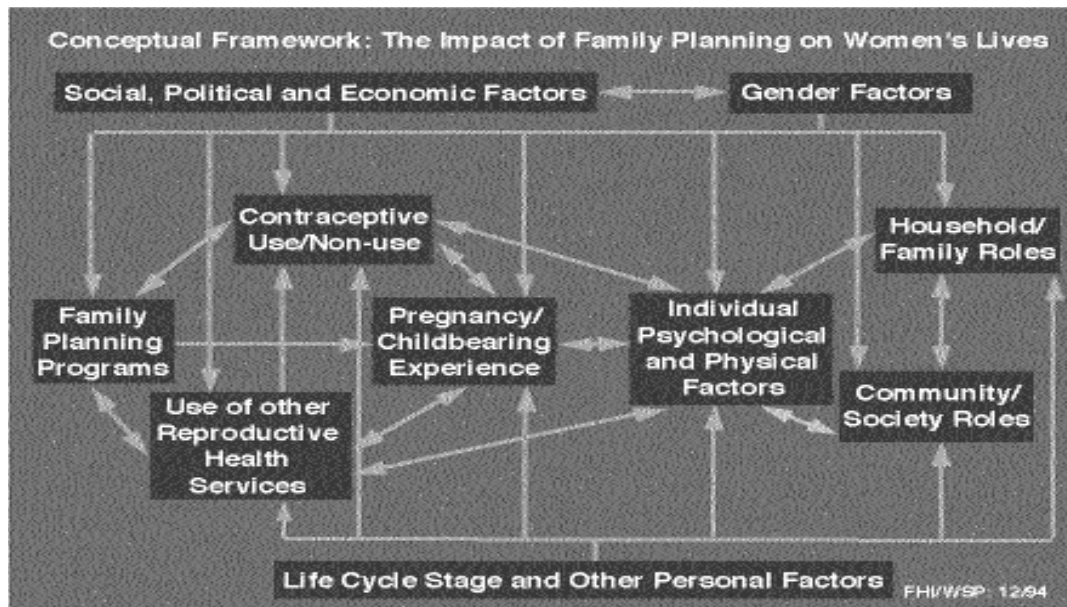


Fig. 5. Conceptual frame work on the impact of family planning on women's lives adopted from FHI-WSP, 1996.

Research Design

This study is primarily a phenomenological study design. However, it is recognized that contraceptive utilization is affected by various factors ranging from personal to institutional, and the personal aspect in turn has complex dimensions such as physiological, psychological, social, economic, and cultural. In order to comprehensively address the wide perspective of such issues, and to place the study findings in the larger context of contraceptive utilization rates and patterns in Ethiopia, the researcher has gathered both qualitative and quantitative data. The qualitative study dealt with the depth of lived experiences of the study participants about contraceptive use-related benefits (Denzin & Lincoln, 2000; Krauss, 2005). The quantitative phase of the study dealt with contextual aspects of contraceptive service users and the service use dynamics. Both qualitative and quantitative data were collected simultaneously. In some literature, such a study can be referred to as a “*convergent parallel mixed methods design*” (Creswell & Clark, 2011; Morse & Niehaus, 2012).

Examining the two different forms of data has enabled integration of the findings and helped to integrate information from both dimensions and improve the scope of understanding. The results enable a robust illustration of the phenomena, with the quantitative results offering some background information related to contraceptive service use and contextualize the

qualitative findings. Synthesizing complementary quantitative and qualitative findings helps to develop a comprehensive understanding of the phenomenon (perceived contraceptive use benefits), to enable a triangulation of the findings (Bryman, 2007; Creswell & Clark, 2011; Morse & Niehaus, 2012).

Quantitative methods. Quantitative methods have been incorporated in this study with the assumption that the context of the phenomena is useful to understand and that contraceptive service usage and patterns can be quantified, measured, and expressed numerically (Schoenbach, 2000). The study has extracted historical data from the available registry in order to generate information about the patterns of contraceptive utilization and to locate and characterize the current contraceptive users. Five years of historical data on contraceptive use and related information were collected from nine health posts in the study area (Byass, 2007)

Data collection. Quantitative data collection procedures entailed several steps. These are 1) obtaining ethical clearance and study permit, 2) development of data collection tool, 3) identifying the health institutions where data was generated, 4) recruiting data collectors and supervisors, 5) training of data collectors and supervisors, 6) pilot testing the instrument, 7) setting detailed data collection schedule, 8) conducting data collection, 9) data entry; and 10) analysis. Common issues such as ethical clearance and study permission will be discussed next to the qualitative approach.

The data collection tool was developed in alignment with the study objective re: contraceptive service use dynamics and the demographic profiles of service user women in the study area. Data gathered included a contraceptive user profile of age, marital status, duration of contraceptive service use, and dynamics of contraceptive use in terms of method use, discontinuation and switching from one method to another. Initially the checklist was developed in English and then translated to Amharic (the National Language of Ethiopia) to make it simpler and more understandable for the data collectors (see annex 6, p. 217).

The data collection sheet originally included the reproductive history of women such as history of pregnancies, child births, abortion/still births etc.; however, after visiting the health institutions (health posts and health centers), we became cognizant that the family planning service use registration books were recently modified for the new health information management system. Therefore we amended the form to include only the existing registration book variables (see annex # 6 for specific variables).

Four data collectors with secondary education completion were recruited. Recruitment of the data collectors and supervisors was done in collaboration with colleagues from Hawassa University and Sidama Zone Health Department. Two days training was given on the overall purpose of the study, with particular attention given on how to retrieve the data from registration documents from designated health institutions.

Quantitative data were gathered from the Health institutions in the same study districts as the qualitative study. Data were collected from nine health posts and three health centers. Nine health posts were drawn from three districts, in the order of four from Boricha, three from Dale, and two from Wondogenet district, respectively.

A pretest of the study tool was done in one health post and one health center outside the chosen districts of Shebedino. Consideration of the health post/health center family planning registration books resulted in further modification of the instrument. The final form was first prepared in English and translated to Amharic.

Data were collected from October 2013 to February 2014 using the Amharic language-based data forms. Four data collectors with two supervisors were involved in the overall data collection process. Data collectors submitted collected data on weekly basis to the supervisors for further review and to check for completion; the supervisor did the same for the researcher. Any incomplete data were returned back to data collectors with remarks. Accordingly, data collectors and supervisors made joint ratifications. Complete data were submitted to the researcher on a monthly basis, signed by both the supervisor and data collector in order to indicate shared responsibilities in the process of data collection.

Out of the nine health posts, six had data for all five years and three of the health posts hadn't had data for 2008/9. No clear reasons were mentioned for the missing year, but were likely due to data mismanagement or lack of competencies of the health extension workers to capture the information adequately in early stages of their service provision.

Data organization and analysis. A summary data insertion template was developed in MS-EXCEL for every health post and each year. All the variables were captured, ordered, and computed. Descriptive analysis was done in accordance to the variable of interest such as age, marital status, duration of contraceptive service use, types of contraceptive method used, history of method switching, and reasons for method switching if any were computed. Proportions and percentage of the designated variables for every health post and each year were presented

separately and finally merged at the zonal level in one grand table. Some variables were also presented in graphic form to make comparison easier.

Data from the three health centers were excluded from the final analysis due to lack of clear catchment area demarcation between the health posts and the health centers in order to avoid the overlap of data between the institutions.

Qualitative Methods.

Interpretive phenomenological qualitative research approach. Phenomenology has a wide array of descriptions based on its historical development and philosophical stances. Many scholars have attempted to define phenomenology reaching only minimal agreement (Moran, 2000 p.3; Spiegelberg, 1982). In general, phenomenology is an approach to inquiry whose purpose is to describe a particular phenomenon, or the appearance of things, as lived experience (Streubert-Speziale & Carpenter, 2003 p.56). Despite the various definitions of phenomenology, for the purpose of this study, I chose the following definition, which states phenomenology as “a study of individual life world, as experienced rather than as conceptualized, categorized or theorized” (van Manen, 1984, p.37). Phenomenology considers that the “true meaning of phenomenon be explored through the experience of them as described by the individual” (Jasper, 1994, p. 309). That is, it aims for a deeper understanding of the nature or meaning of every day experience. Hence, phenomenology can be described as having philosophical, theoretical, and methodological dimensions.

According to Willig (2001), the central assumptions of phenomenology are that perception is viewed as the primary psychological activity; understanding is considered the true end of science; multiple perspectives are equally valid as they represent different self-worlds; and perceptions are based on hidden assumptions which phenomenologists also try to understand.

Phenomenology offers an approach that has a good fit with a holistic view or philosophical stance for health care delivery inclusive of population health, because of its focus on understanding individuals and their meaning and interaction with others and the environment (Lopez & Wills, 2004). Similarly, reproductive health, as a branch of population/community health, concerns itself with human responses to the actual and potential health outcomes/problems; knowledge in population health must reflect the lived, contextual realities and concerns of the population for whom the health services are provided (PBR, 2012; Health

Canada 2001). Researchers and practitioners of health sector in general and population health/ community health in particular necessitate the development of knowledge and skills that are culturally relevant and respectful of the social realities of those living within the situation (Waters, 2009).

Phenomenological approaches are mainly classified into two categories: descriptive and interpretive (hermeneutic) (Cohen & Omery 1994). These two approaches differ in how findings are generated and used to enrich professional knowledge (Lopez & Willis, 2004). The descriptive (eidetic) phenomenology is based on the philosophical assertion of Husserl, a German mathematician and philosopher, considered a founder of phenomenology. According to him, subjective information is important to scientific inquiry to understand human motivation, because human actions are influenced by what they perceive to be real (Benoist, 2003; LeVasseur, 2003; Maggs-Rapport, 2000). Thus, his scientific approach became crucial to discern the essential components of the lived experiences specific to people. In order to describe the essence in its purity as experienced by people, Husserl believed that the researcher's prior personal knowledge should be 'bracketed' to prevent biases and preconceptions influencing the study (Drew, 1999) and ensure scientific rigours. Husserl, in this regard, has presented two assumptions: that there are universal essences or eidetic structures that are common to all persons who have a lived experience, and the suggestion that the issue of 'radical autonomy' which explains the importance of culture, society and politics on the individual's freedom of choice is not central (Lopez & Willis, 2004).

The second category of phenomenological research approach and the one which I chose for this study is an interpretive (hermeneutic) approach developed by Martin Heidegger, the successor of Husserl. Heidegger's central tenets of understanding a phenomenon is through exploring the lived experience of a person in relation to a phenomenon (Lopez & Willis 2004; Smith, 2004). He suggested that the perception and meaning given to a phenomenon cannot be considered in isolation of the underlying contexts such as social, cultural, and political (Campbel 2001; Leonard 1999). With the intention of elaborating the issue clearly, Heidegger used the term '*life world*' to express the idea that individuals' realities are invariably influenced by the world in which they live. The freedom of the individuals to choose is usually circumscribed by specific conditions of their daily lives. Consequently, the hermeneutic phenomenologists focus on describing the meaning of the individual's '*dasein*' and how these meanings influence the

choices they make, rather than seeking purely descriptive categories of the real, perceived world in narratives of the participants (Flood, 2010).

Another central philosophical assumption to the interpretive approach is the consideration of the expert knowledge of the researcher as a valuable guide to the enquiry. Heidegger (1962) emphasized that it is impossible to rid the mind of the background of the understandings that has led the researcher to consider a topic worthy of research. Given the preponderance of literature that suggests the influence of cultural and social factors on contraceptive use, and given my educational background and history of working in rural Ethiopia in the area of reproductive health, the interpretive approach is most apt for this study. Thus, I have chosen to use the interpretive phenomenological method for investigating the perception of women about their experiences with the use of contraceptives to allow me to take into account the basic consideration of unique individual perspectives within a particular context, and in order to recognize what I also bring to the analysis (van Manen, 1984). Exploring the lived experience related to contraceptive use by employing this approach clearly offers a unique opportunity to establish a rich and in-depth understanding about the contribution of contraceptives toward the empowerment of women, the improvement of the health of women and their children, and the society at large (Munhall, 2012, p. 128).

In order to broadly capture information related to the topic of interest, the study has utilized three data collection methods: key informant interview, the focus group discussions (FGDs) and the individual in-depth interview. The overall qualitative data collection and related subsequent undertakings necessitated research assistants who have helped in the facilitation of research field-work (contacting the health extension workers and community leaders and recruitment of study participants).

Data collection method.

Recruitment of the research assistants. The nature of qualitative data collection strongly requires that researchers or research assistants ensure the quality of data generated. In this particular study, research assistants were employed for two main reasons. First, study participants for the focus group discussions and individual interviews were women and the topic entails a sensitive issue of reproductive health and sexuality. Therefore, employing female research assistants not only facilitated the data collection process, but helped to explore the details of women's lived experiences that would not be possible with discordant gender. Second,

the research assistants helped in bridging the language barrier between the researcher and study participants (most rural women do not speak languages other than their local tongue, in which the researcher is not literate).

Hence, the recruitment criteria for research assistants considered issues of being female, being fluent in the local and national language as well as English, and having relevant educational qualifications (MA/MSc or BA/BSc) with relevant research fieldwork experiences in qualitative research and reproductive health issues.

In the process of recruitment, I used several means to identify potential research assistants. The Hawassa University Community-University Linkage Office under the office of Vice President for Research and Technology Transfer, the South Nations Nationalities and People's Region Health Bureau, the Sidama Zone Health Department, friends and colleagues were all involved in the search process. It had been a challenge for me to find a woman with the best desired qualifications and related experiences who spoke the local language. As a result, I was forced to pursue the second option (a BA/BSc educational preparedness and relevant experiences). With the help of the above organizations and individuals, I recruited two women research assistants with Bachelor degrees in Public Health and Health Education who spoke the local language perfectly. All administrative procedures were conducted in accordance with the Ethiopian government regulations. The research assistants signed working agreements with the researcher in the presence of a witness and copies of the agreement were submitted to Hawassa University for administrative purposes.

Training of the research assistants. Two days of training were given at Hawassa University main campus using a training manual developed for this purpose (see annex #1, p. 199). The training encompassed a briefing of the overall purpose of the study and methodology of qualitative study with a major emphasis on the recruitment process of the participants and field data management aspects. The issue of an ethical process in approaching women and other research team members to ensure the rights and privacy of study participants across the whole data collection process was given adequate attention. A field test was done after training in a district (Shebedino) other than the study districts. For the field test, each assistant conducted two individual interviews in the presence of the researcher in the following manner. I first explained the whole purpose and processes of the study in Amharic to the research assistant and the research assistant in turn translated it to the woman in Sidamigna. The research assistant asked

the woman for her understanding of the issue and then the assistant translated for me in Amharic. In this way we reached an understanding of the completeness and or any gaps in the translation processes. We also held a discussion about the quality of the pilot interviews and difficulties encountered. The field test went smoothly and provided remarkable insight for the research team.

Meeting with the health extension workers and selection of the female community leaders.

Before going to the health post/*kebele* level, all the necessary ethical and administrative procedures were effected (see section under ethical clearance). Letters from the district offices were produced and submitted to both the health post and *kebele* administrations. At the health post level, information about the research was first provided to the health extension workers. The health extension workers noted the importance of meeting female community leaders in order to facilitate participant recruitment together with the health extension workers. The health extension workers identified the female community leaders, and a half-day discussion was then held about the research process and participant recruitment at each health post.

The discussion was mainly focussed on the way to ethically recruit study participants based on the criteria. They were clearly informed about the right of the study participants to choose whether or not to participate in the study. Participation in the study was only by their informed consent and was without obligation or coercion. However, the research team was also encouraged to emphasize the importance of participation to the study and subsequent contributions to the improvement of contraceptive services in their area. The health extension workers and women community leaders were given selection criteria in written form to recruit for FGD and individual in-depth interviews.

Participant selection. A purposive sampling method was employed in choosing information-rich participants (Denizen & Lincoln, 2000; Patton, 2000) within the three study districts and nine health posts and *kebeles*. Participants meeting the following criteria were selected: 1) women of the reproductive age group that were using any type of modern contraceptive method before and during the study period; 2) women who used contraceptives for at least one year; and 3) women who could express their feeling openly as might be verified by the community leaders. Participants were selected in the following manner: 1) potential participants (women using contraceptive method) were approached by the community leaders and informed about the study purposes; 2) names of interested participants for both the focus

groups and the individual interviews were submitted to the research assistant and the researcher. A total of 82 women representing the reproductive age group were enrolled and participated in the focus group discussions, comprised of seven -to -twelve participants in each FGD (see table # 4 below for the details of FGD participants' profile). For the individual in-depth interview, a total of eighteen reproductive age group women were enrolled from nine *kebeles* (see table # 5 on the next page for details).

Key informants involved in the study ranged from the health extension workers at the basic grass- roots level to high-ranking officials at the Federal Ministry of Health. Selection of the participants as based on the set criteria in the study protocol. At the health post level among the health extension workers, the worker with the most experience was chosen. In other hierarchies of health service management and health centers, designated position-bearers were chosen automatically. Accordingly they were the district head, maternal and child health unit coordinator at the district and health centers, deputy head and director for health program at the regional health bureau, and the director for the reproductive health at federal Ministry of Health. Due to busy schedules, it was difficult to reach the zonal health department head for discussion despite repeated attempts. Each key informant interview lasted from 45-60 minutes. See brief narrative p. 56 for the detail profile of key informants.

Table 4. Profile Summary of FGD Participants

Address of Participants	# of participants	Average # of children	Average age	Average year of service use
Waycho	11	5.1	29.64	7.54
Gane	10	5	29.4	4.2
Korangoge	9	4.4	26.44	5.88
Woteragendo	8	5.25	29.4	3.34
Degara	7	3.7	22.57	4.86
Konsore fullasa	7	3.7	27	4
Gassara Kuwie	10	4.6	31	5
Dilarife	8	4	30.38	7.2
Baja Fabrica	12	4.75	31.75	5.16
Total/average	82	4.5	28.62	2.24

Table 5. Profile of Women Participated in Individual In-Depth Interview

Age	Education/yrs. attended	# of children	duration contraceptive use in yrs.
24	5	4	5
30	7	4	7
30	6	4	2
23	6	1	3
30	-	5	10
25	-	2	5
30	7	5	4
30	-	5	5
30	7	4	5
20	2	2	4
30	-	7	7
25	-	4	6
25	5	3	3
27	7	4	12
32	5	4	3
30	10+2	4	4
28	5	4	5
32	8	7	6
27.83		4	5.3

Narrative profile summary of key informants. A total of eighteen key informants; nine women and nine men were participated in key informant interview. The participants were from Ministry of Health (head office), Regional Health Bureau, District Health Office, Health Centers and Health Posts. With regard to participants educational status; it ranges from a one year certificate training up to medical specialties and master degree in public health. The key informants also diversified in their professional backgrounds; some of them are medical doctors, others are health officers, nurses, rural development workers and the health extension workers. Key informants had rich work experiences ranges from two to thirty-one years with an average of ten. They are also diversified in their age distribution that ranges from twenty-three to fifty-one with an average of 30 years.

Data collection for qualitative method. A semi structured interview guide was developed addressing all study questions and objectives. This type of interview guide is assumed to be in line with the interpretive phenomenological approach that gives reasonable freedom for the participants to express their experiences to the phenomenon of interest in their own ways. Though it is understandable that questions for the qualitative method would emerge during the whole data collection period depending on the situation, it was important to include all potential areas related to the women's perception of the benefits of contraceptive utilization in terms of their economic, psychological, and physical empowerment, as well as it being a factor in their attaining desired levels of fertility and improving their health status and that of their children. The semi-structured interview guide and subsequent probing encouraged participants to speak about their experiences and deepened discussion and reflection on their lived world (Munhall, 2012; van Manen, 1997).

In a phenomenological study, it is important to consider how to generate rich, in-depth information. When a researcher uses various qualitative data collection methods, the likelihood of improving the quality of data generated is enhanced. With this notion, the researcher has used a triangulated approach and derived data from various methods: key informant interview, the focused group discussions and individual in-depth interviews.

Key informant interview. A total of eighteen key informant interviews were conducted for this study. All the informants were either service providers or health service managers at various levels of health services hierarchies. Before the actual data collection, flexible interview dates were arranged. Most of the key informants were busy with their official routines; therefore

flexibility on behalf of the research team was a necessary condition. After identifying the key informants, an interview schedule was fixed either by face to face communication or over the telephone. All the key informants' interviews were conducted in the informant's office or working unit at a time of their convenience. On the day of the interview, the research team arrived 15-20 minutes earlier than the scheduled time in order to check all the materials were functional and in their proper place. Just on time, the researchers courteously knocked on the door of the informant office and requested entrance. With permission to enter, the team introduced themselves to the informant in a respectful manner. Copies of study support and ethical clearance letters were presented to the informants after establishing a good rapport. Time was given to the informants to read both letters before the commencement of the interview.

After making sure that the informant had gone through the letters, the research team asked permission to continue and gave the informant a consent form to be read and signed. Concomitantly, the research team briefly explained the purpose of the study, the procedures how the team ended up in selecting the informant and the overall process of the study. Once the research team obtained a final signed consent form from the informant (see appendix #13, p.222), we conducted interview discussion in the following steps. First we ensured the room was a convenient space in which to conduct the interview without disturbance and that the informant and the research team members got a comfortable seat. Then, we set the audio recorders on and the research assistant ensured her readiness to take notes during the interview. Permission was obtained again to tape record the discussion. By using the semi-structured interview guide, the interview was conducted in a flexible and systematic way.

In accordance with the nature of the qualitative study and the interpretive phenomenological design, thorough discussion was carried out under each study guide question with many opportunities to probe further as issues emerged. In this way, the interviews lasted from 60 to 90 minutes. Then the research team made sure the entire interview was documented both in the form of an audio recording and written notes. Finally, the research team thanked the informant for her/his time and information before leaving the office, mentioning the possibility of returning after the preliminary analysis for further discussion. All eighteen key informant interviews were conducted in this manner.

Focus group discussion. The purpose of focus group discussions (FGD) is to gain knowledge of a particular topic by interviewing a group of people directly involved or affected by the issue (Kruger & Casey, 2009). Focus group discussion was appropriate for this study as it helped to explore the experiences and perceived benefits of contraceptive use of women of reproductive age in detail. A total of nine FGDs were conducted from the three selected study districts each per *kebeles* (health posts). Eighty-two women of reproductive age who satisfied the recruitment criteria were involved in 9 focus group discussion sessions. The number of participants in each session ranged from seven to twelve.

After the recruitment process was completed and a list of women from each *kebele* submitted, a date for FGD was scheduled in consultation with the health extension workers and women leaders in the community. Discussion and arrangements of dates was done with due consideration of the time and rhythm of rural women. All the discussions were done on non-market days and from 10:00-11:30 AM. This time interval was chosen based on the recommendation of women and their leaders. Women were contacted through the women community leaders and the health extension workers about the date, time, and place of the discussion.

The research team as usual arrived at the research site 15-20 minutes earlier than the actual time to ensure adequate time for the preparation of materials. The room in each respective health post was checked for the proper seating arrangement. The seating arrangement was done in a circular fashion so that everybody could have ample opportunity to properly see one another.

Once the study discussants took their seats, the health extension worker carried out greetings and introduced the research team. The health extension worker then left the room to give the discussants freedom in their discussion. Following the introduction, the researcher and assistant clarified the purpose of the study informed discussants of why and how they were selected for participation in the study, and of the right of participants to continue in the discussion or withdraw.

The research assistants read the written consent and translated into the local language to the discussants. Adequate time was given for every statement during translation to ensure the women understood the message clearly and were fully informed prior to giving consent (see annex #14, p. 223). After discussing the consent form with the women, permission was

requested to audio-tape and take notes of the discussion. We explained that the audio-taped materials would be destroyed following completion of the study processes.

After obtaining their permission to audio-tape and take notes, discussion was conducted. The researcher moderated the discussion session and the research assistant provided direct translation to the women. Discussion was conducted by giving enough time for the women to raise issues related to the guided questions. Care was taken to involve all discussants equally so each could discuss her lived experiences. Discussion sessions were conducted for 60-90 minutes with consideration to the women's schedules. All the audio-taped materials were checked for completeness and discussants were acknowledged for their commitment and invaluable contributions. Discussants were notified of the necessity of at least one more subsequent meeting following the preliminary analysis of the first discussion.

Two digital recorders were used to audio-tape the discussions in order to ensure accuracy and prevent against equipment failure. Each focus group discussion was given a specific identifier to differentiate it from subsequent discussion and avoid confusion during transcription.

Individual in-depth interviews. In addition to the two data collection methods described above, individual in-depth interviews were carried out with women using contraceptives over longer durations (the minimum use time considered for this category was eighteen months). A total of eighteen individual in-depth interviews were conducted. Recruitment of the interviewees was based on the previously described long-term use criteria. All communication with women occurred in their own language. The research team conducted the interviews at either the residence of the women or at the health post depending on the preference of the interviewee. For those conducted in the home, the research team was guided to the house by either the health extension worker or community leader or both. Upon arrival at the house of the interviewee, the research team offered courteous greetings and waited for permission to enter the house. Once allowed entry, the interviewees provided seating prepared in knowledge of our arrival. In appreciation of their offer, we introduced ourselves and began to explain the purpose of our visit. For those interviews conducted at the health posts, the interviewees arrived at the health post at the pre-arranged time, and were offered a seat by the research team. As usual, an introduction of the research team to the interviewees was carried out before the commencement of the interview.

After the personal introduction and greeting, researchers explained the purpose of the study, how women were enrolled to participate and what was expected from them. A consent

form was read and translated to the women. Agreements to participation were indicated by signature. Permission was obtained to continue the interview and record the interview via audio-tape and taking down notes.

Once permission was obtained, the researchers conducted the interview using the semi-structured study guide questions. Audio-recorders were located close to both the research team and the woman. The researcher probed beyond each question based on the response of the participant. Adequate time was given for her to comfortably and exhaustively respond to the questions. Moreover, the interviewee was encouraged to talk about her lived experiences in detail without any shyness or discomfort.

The interview continued in such a way from forty to sixty minutes until the study team felt that the ideas emerging appeared to repeat, suggesting saturation. Before closing the interview session, the team showed appreciation to the woman for her devotion and for sharing such invaluable life experience. The team mentioned a potential return for further discussion following analysis of the preliminary results. All eighteen individual interviews were conducted in this manner.

Data analysis. Qualitative data analysis as defined by Bogdan and Biklen (2003, p.100) as “working with the data, organizing them, breaking them into manageable units, coding them, synthesizing them, and searching for pattern”. Data analysis in qualitative study necessitates searching for meaning through direct interpretation of what is observed as well as what is experienced and reported by the study participants. Qualitative data analysis thus actually begins when the researcher starts data collection either in the form of an interview, group discussion, or any other method (Merriam, 2002; Stuckey, 2014). The researcher is therefore encouraged to be conscientious about data collection to facilitate the steps of subsequent data analysis. In this study I have taken great care in generating appropriate data that considers both the contextual environment and the participants’ lives as data sources. The data collection process, including relatedness and connections to the contextual environment, interview and discussion processes, and the energy and action of engagement during the interview processes were all considered to be significant components of data analysis (Meyrick, 2006).

Following careful attention to the creation of appropriate data, qualitative data analysis becomes an iterative process where one must look into multiple dimensions and interactions, often going back and forth or in circular patterns to examine the data (Ajjawi & Higgs, 2007).

This study used the guiding principles of interpretive phenomenological methodology to explore the lived experiences of women's contraceptive service use, their perceptions of related benefits and the enabling environment (particularly as perceived by the service providers and health managers), in conjunction with the experience of the researcher as a professional and member of the community. Interpretive phenomenology has further framed the analysis by viewing the phenomenon in such a way that considers the close interaction between the participants and researchers as instances of their 'being in the world' rather than only 'being' itself (Lopez & Willis, 2004; Smith et al., 2009). Hence the study diverges somewhat from interpretive phenomenology by adding an analysis of quantitative data to help fix the data in context. An adapted flow diagram from the IPA was used to guide the analysis (see annex # 2, p. 206). The following summarized steps were used in guiding the analysis:

1. Transcriptions were made of all the audio-taped materials verbatim, first from Sidamigna into Amharic and then to English. Materials were also translated back to Amharic by a linguistic professional. The Amharic translation was then given to the research assistant to translate back into Sidamigna, after which the document was reviewed for consistency. Most of the individual in-depth interviews and all FGDs were transcribed by the research assistants, and the key informant interviews were transcribed by the researcher. All key informants speak the same national language as the researcher. In the case of women of reproductive age, except for a few, the majority only speak the local language, Sidamigna. Study participants were given chance to see the transcribed data and summary results and made comments based on their impressions. Field notes were organized under the guiding research questions.
2. Efforts were made to link the hand-written field notes to the transcriptions through consideration of the field data collected during the taping. The hand-written notes were taken down while participants responded to the study guide questions posed by the moderator. The notes provided a comparative resource to the audio transcriptions. Any additional or different ideas or concerns from the field notes are incorporated into the transcripts.
3. Data immersion by the researcher has taken place by reading the transcripts several times. English version transcription was used for analysis. Repeatedly reading and re-reading the material has revealed recurring ideas and concepts. This step was carried out

for all transcribed materials from the key informant interviews, FGDs and individual in-depth interviews.

4. In the data immersion process, several visits were made to the study participants as a first step in identifying descriptive codes and checking preliminary interpretations. The participants commented on some points following an initial description of the issue(s), and these were incorporated into the second round of data analysis with remarks.
5. Margin notes and descriptive coding were then completed for all the materials
6. Data reduction was done in a step-by-step approach, beginning with the transcripts, followed by descriptive coding, and then distilling this material into themes by bringing similar ideas and concepts together (see annex#4, p. 208).
7. Deriving themes was done with consideration of both analytical themes and research questions.
8. The analysis process has also given attention to the hermeneutic circle; the back and forth iterative linking of data from both the perspective of both the researcher and study participants (see annex #5, p. 211). These steps were done by re-visiting the transcripts after major themes had been identified in order to interpret connections between the initial data and our later refinements (Bontekoe, 1996; Wojnar & Swanson, 2007). Summarized reports were presented to the study participants about the phenomena derived from their shared experiences. Discussions were held with participants about the study guide questions and core concepts of the study. Their feedback was then considered alongside the experiences of the researcher. This increased our confidence in our interpretations, and further enriched our understanding about the phenomena.

Quality assurance (Reliability, validity and trustworthiness). Research undertakings generally require ways of ensuring quality in terms of how the overall study processes have been managed. While quantitative research often discusses validity, qualitative research ensures the quality of the research output in part by carefully recording all data collection and analysis steps (Davies & Dodd, 2002, Patton, 2002). In this study, quality assurance or trustworthiness of the results used four criteria- credibility (truth value), transferability (applicability), dependability (consistency), and conformability (neutrality) suggested in the literature by Curtin and Fossey (2007), Rolfe (2006), and Morrow (2005). The four criteria were considered in the following manner:

1. Credibility

Credibility is usually achieved when participants demonstrate feeling of the research findings as their own experiences (Shenton, 2004, Streubert-Speziale & Carpenter, 2003). To ensure credibility of the study, the following steps were conducted: 1) I have presented summary of transcripts to the study participants to give them an opportunity for further comment 2) I have done a review of preliminary findings with key informants in the field, such as health extension workers, to ensure that the early findings reflect what they know of women's lived experiences.

2. Transferability

This refers to the probability of the study findings having meaning to others in similar situations. It can be determined by the potential of those other than the researcher using the research findings (Golafshan, 2003). In this study, the preliminary summary findings were shared with the health managers and service providers to check interpretations. Moreover, the final result will be shared in the form of workshop presentations and scholarly publications once all the necessary steps are complete.

3. Dependability

Dependability is a criterion used to measure the trustworthiness of the findings, confirmed in the stability of data over time, which can be obtained through replication and inquiry audit (Golafshan, 2003; Polit & Hungler, 2004). In order to ensure the dependability of the study, I have indicated the detailed steps of the field work

including the process of data gathering using the overlapping methods of focus groups, individual interviews and key informant interviews (Shenton, 2004).

4. *Conformability*

Conformability is concerned with the degree of neutrality of the researcher or the extent to which the researcher controls personal bias or presupposition (Curtin & Fossey, 2007). I used an interpretive phenomenological design guided by feminist theoretical framing for this study that permit the joint interpretation of a phenomenon where both the researcher and participants experiences are valued and accepted. Therefore, I have little worry about the effect of personal bias on the study outcomes. However, in order to ensure conformability in the study, attention was given to balance the joint interpretation of the results by substantiating the findings with direct quotations from study participants.

Ethical considerations. The University of Saskatchewan uses the Tri-Council research ethical review document for all its research undertaking. Ethical consideration of this particular study involved many stakeholders ranging from the community women to local health managers. Elders and community leaders also participated in the research. Therefore, the ethical approvals had to be in accordance with the ethical principles of the University of Saskatchewan and Hawassa University, as outlined below (Canadian Institute for Health Research, 2010).

Ethical clearances were obtained from the University of Saskatchewan Research Ethical Review Board, Canada and Hawassa University Institutional Review Board, Ethiopia (see annex #8, p. 220 and #9, p.222). Obtaining independent ethical clearance from each nation is required as every nation is autonomous and might have its own special approach. Ethical clearance was first obtained from Hawassa University and a copy of that was submitted to the University of Saskatchewan IRB as part of the ethics submission.

Research support and permission letters were also obtained from various offices with in the SNNPR. First, the Regional Health Bureau was approached to obtain the support letter by presenting both ethical clearance documents. The regional health bureau checked the request through its research directorate and offered a support letter to Sidama Zonal Health Department. Likewise, the Sidama Zonal Health Department gave a support letter to the respective districts where the study was conducted. In similar manner, the districts health offices were given support letters to the respective health posts and *kebeles* ensuring that the study was accepted.

Support letters from the districts were submitted to the health posts and community leaders. Support from the health posts and community members were obtained in formal ways to reach to the study participants (see annexes 10- 12, pp. 223-225).

The rights of research participants were maintained by ensuring non-maleficence and underscoring the benefits of the study. Study participants were adequately informed about the purpose of the study and their right to participate or withdraw at any time they wished as outlined in the ethical clearance document. In order to ensure their privacy and autonomy, participants were also informed that the study does not identify them by their names in connection to the study findings or in their answers in the discussions or interviews. The participants were given time to reflect and were provided a detailed explanation of the issue so that they could reach a clear understanding of the study, free of any external influence or inadequacy of information.

Informed consent was secured from study participants after providing detailed information about the purpose of the study. The written consent form in the local language was read for the participants in the manner they understand. Those participants who couldn't read and write offered their consent by marking documents with their fingerprint once a thorough understanding of the implications of consent was established. Participants were given the opportunity and encouragement to ask questions on any unclear points in connection to the study. The benefits of the study to the [socio-economic and health development] systems were also emphasised during the explanation. The study only commenced upon receiving written and /or verbal consent of participants (see sample of the signed consent forms in annexes 13-14, pp. 226-227).

Scope, limitation, and delimitation. The study is largely based on primary data, which can be stated as its strength. In addition to primary data, the study uses mixed methods, employing qualitative and quantitative approaches that each complements the other. The research also addresses in particular the under-emphasized topic of how the perceptions of Ethiopian women of reproductive age on the experiences and benefits of contraception. More importantly, the research is to be conducted in university-selected longitudinal research sites which are important for subsequent researchers and the potential of service improvement by the local health authority. Being conducted in the rural regions of Ethiopia with selected rural

women, drawing from their lived experience and perspectives on rights and empowerment are additional merits of the study.

The limitations of the study may be found in that is considered only married women, and in only three districts. The sensitivity of the issue of contraceptive utilization may be one factor that limits the response during data collection. Another possible limitation is that the study hasn't considered current non-users' perception about the benefits of contraception. The decision to not involve men in the study may be another limitation in need of future consideration.

Delimitation. The delimitation of this study is explicated in terms of the study purpose, the selection of study area, and selection of study participants. The study was carried out with the intention to explore the experiences of women contraceptive service users in the Hawassa University research villages. University research villages are established with the intention to observe the impact of university-based research in knowledge generation, technology transfer, and the livelihood of the residents. Thus, the study was conducted in this area to suit the university's intentions. The purpose of the study was to explore the experience of women currently using contraceptives and their perceptions of the benefits of contraception on health and empowerment. It is only through the life world of the user that such experiences can be ascertained. The women who never used the service are less likely to have such experiences and were therefore not considered for the study. The non-user women can benefit from the study if outcomes produce favourable results.

Conclusion. This study used an interpretive phenomenological approach and a mixed method design, employing both quantitative and qualitative methods. The quantitative aspects of the study included secondary data from the health institutions and employed descriptive statistical analysis to provide context, whereas the qualitative methods gathered primary data from interviews and focus groups and employed an interpretive phenomenological analysis. The majority of data were collected from women of reproductive age and from services providers. Findings of the study follow.

CHAPTER 4-RESULTS

The study was conducted under the broad premises of a mixed method design (Creswell, 2013; Creswell & Clark, 2011) encompassing both qualitative and quantitative methods. The preponderance of data was qualitative, with the context for the study described through analysis of quantitative data. In this chapter, I present the quantitative results followed by the qualitative. Results of the study are presented under the two broad study questions relating to women's perceptions of health benefits and the empowerment potential of contraceptive use, as well as health provider efforts at creating an enabling environment. Each section is further divided into sub-themes, which emerged in the data analysis. The quantitative section describes the patterns and trends in contraceptive utilization in the Sidama zone to enable the reader to better grasp the context of the study.

Importantly, the qualitative results evolved through several steps of translations. Women who participated both in the FGDs and individual in-depth interviews speak local languages that I do not speak. Hence, the transcription of audio material from Sidamign (the language spoken by the study participants) to Amharic (the national language of Ethiopia) was done by the research assistants. Then the Amharic version transcript was translated to English by me. Language experts then translated transcripts back from English to Amharic and to Sidamigna. The same process occurred for sharing preliminary results. After these steps, the preliminary results were discussed with research participants to get their input, and to discern whether they felt that the findings reflected their experience. All the quotations posted in the text are the translated version of the participants statement checked for their equivalency in English. Because the English translators looked for concepts that reflected what the women said, the quotes appear to use more technical language than what may have been used by women participants in their original language.

Quantitative Result

The results posted here are a summary of the data from each study area (nine health posts under Sidama Zone). The quantitative results capture the total population, the reproductive age group women and eligible women for contraceptive service for the five year period (2008/9 to 2012/13) in the selected study area. The other variables included are the age of women using the service in a five years age interval, marital status, duration of contraceptive use, types of

contraceptive methods, reasons for contraceptive use, history of method switch and reasons for a change in chosen method (if any). Table 6 reveals that the total population of reproductive age group women and eligible women for contraceptive services increased from 2008/9 to 2012/13, somehow corresponding to the natural increase of population in the country (CSA, 2011; Sidama Zone health profile, 2012). According to the national and regional indices, reproductive age group women contribute to the twenty three percent of the total population. Eligible women for contraceptive services are nineteen point five percent of the total population and less of current proportion of pregnant women from reproductive age group women. The current pregnancy rate in the study area is expected to be three point eight to four percent (Sidama Zone health profile, 2012). Population size is not uniform in all study *kebeles* with variation in both number and catchment area diversities. The total population shown in table 7 below doesn't strictly corresponds to the national natural population increase rate. The reason for the variation may be a documentation problem related to the competence of health extension workers or might be an error on the baseline population where the 2008/9 projection was done.

Table 6. Total Population, Reproductive Age Group Women and Eligible Women for Contraceptive Service in the Study Area, Sidama Zone, SNNPR, Ethiopia from 2008/9 to 2012/13.

Variables					
Fiscal year	2008/9	2009/10	2010/11	2011/12	2012/13
Total population	43776	61626	64103	65814	67859
Reproductive age population	10200	14415	14955	15336	15785
Eligible population for FP	8537	12017	12499	12833	13233

As shown in table 7 below, contraceptive use of reproductive age women varied in age intervals. Close to sixty percent of contraceptive service users in the last five years were found

in the age interval from 25-34 years. The number of service user women is reduces when their age increases to the highest interval. For example, only near eight percent of service users were in the age interval from 40-49 years. Number of service users also fewer at earlier ages. Only twenty three percent of service user women came from the age range 15-24. This indicates that at early and late age service users are less comparable to the middle intervals.

Table 7. Proportion of Contraceptive User Women at Various Age Interval and in Five years duration (2008/9-2012/13), Sidama Zone, SNNPR, Ethiopia

Age interval	2008/9	2009/10	2010/11	2011/12	2012/13	Total	%
15-19	63	213	346	391	294	1307	6.5
20-24	339	664	728	896	742	3369	16.7
25-29	691	1467	1506	1684	1887	7235	36
30-34	455	627	869	924	1313	4188	20.8
35-39	384	368	400	473	760	2385	12
40-44	142	214	175	231	285	1047	5
45-49	42	93	156	106	238	635	3

With regard to the marital status of women, almost all (ninety eight percent) of women were married. Less than two percent were not married, with divorced and widowed. Concerning to the longevity/duration of contraceptive use in the last five years (2008/9 to 2012/13), the study is presented within four intervals as depicted below in figure 6. Nearly sixty percent of contraceptive user women have used the service for about 1-5 years. Only a quarter of the study women have used the service for more than five years. This indicates that contraceptive service use is short-lived, or that women use it for only temporary purposes such as spacing between births, for short periods of time. When each year is examined separately, there is a change in the trends of longevity. For instance, there is an overall increase in service use for longer periods as the year increases from year one onward. In 2008 nearly 700 women used service for two to five years but in 2015 more than 2000 women used for the same duration.

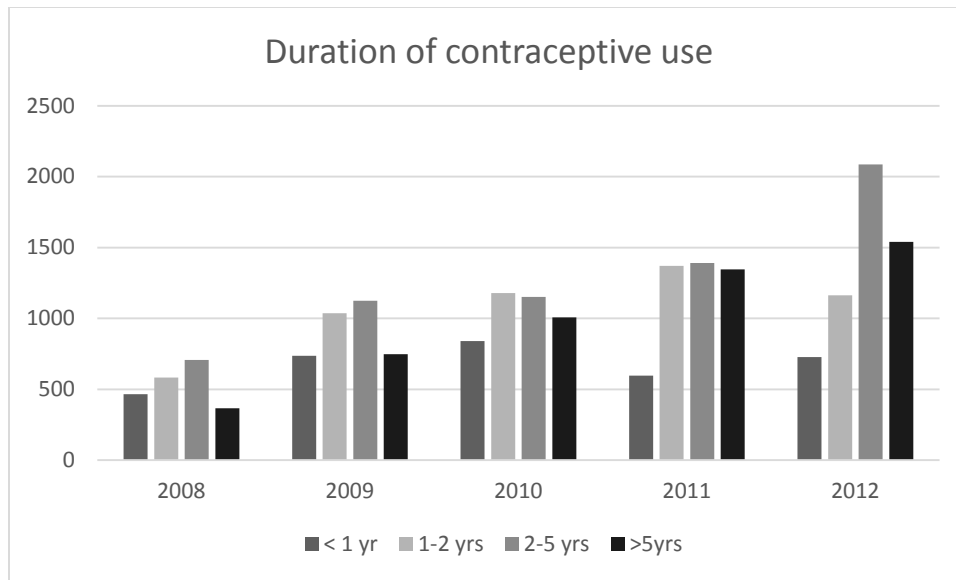


Figure 6. Duration of Contraceptive Service Use by Reproductive Age Women, Sidama Zone, SNNPR, Ethiopia, 2008/9-2012/13.

Women used various methods of contraception in the past five years. These include oral contraceptive pills, injectable method, the loop, Implanon, condoms, and permanent methods such as tubal ligation. Though these methods are available, the result indicates that the majority of women used the injectable method followed by the oral pill. More than two-thirds (seventy four percent) of women used the injectable method (Depo-Provera). The oral pill accounts to about thirteen percent of the total. The remaining methods such as Implanon (a surgical implant), IUCD, condoms, and tubal ligation account for the remaining proportion. The result in this study indicates that nearly ninety percent of users only used temporary/short acting methods.

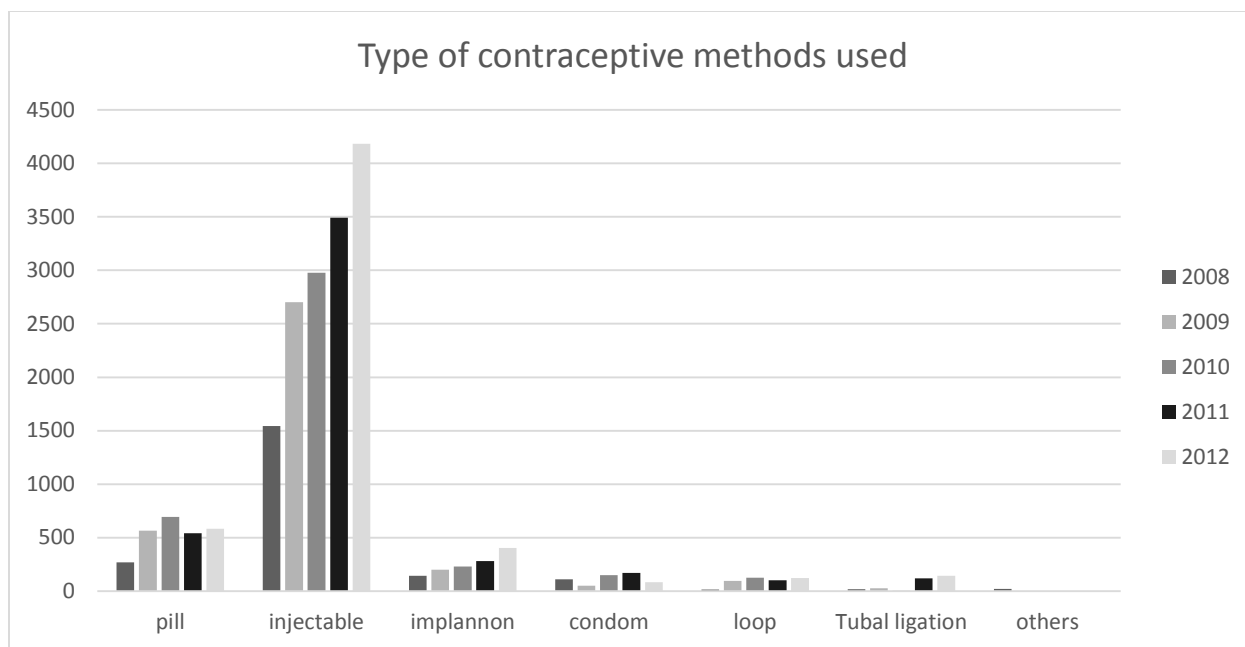


Figure 7. Type of Contraceptive Methods Used In Sidama Zone, SNNPR, Ethiopia from 2008/9-2012/13

With regard to the purpose of service use, only three point six percent of service users stated they used the service to limit the number of children or totally stop pregnancies. The rest used the services to delay times between pregnancies. Only about three point five percent of the total service users reported that they changed their chosen method. Among those three point five who had switched methods in the past five years, ninety eight percent did so due to side effects of the former method. The rest are due to either method failure or absence of the former method which they had been using.

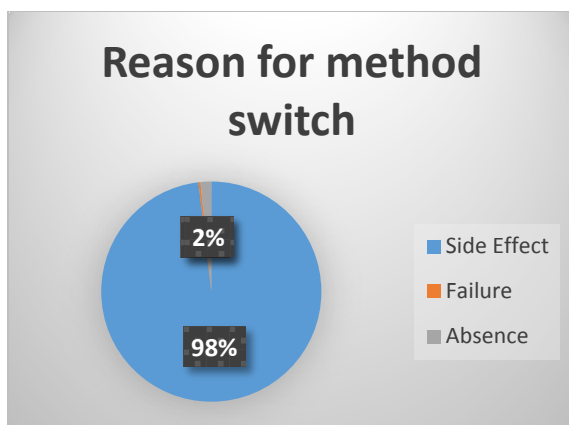


Fig. 8. Reason for Contraceptive Method Switch by Service User Women, Sidama Zone, SNNPR, Ethiopia from 2008/9-2012/13

The prevalence of contraceptive use is determined in this study by dividing the number of contraceptive service users to the total eligible women for contraceptive services for each year. Accordingly, contraceptive prevalence showed steady progress in the last five years. It was twenty five percent in 2008/9 and reached forty two percent in five years' time, a total of seventeen percent increase in the last five years. This has indicated that there are positive signs of service use as compared to the previous era.

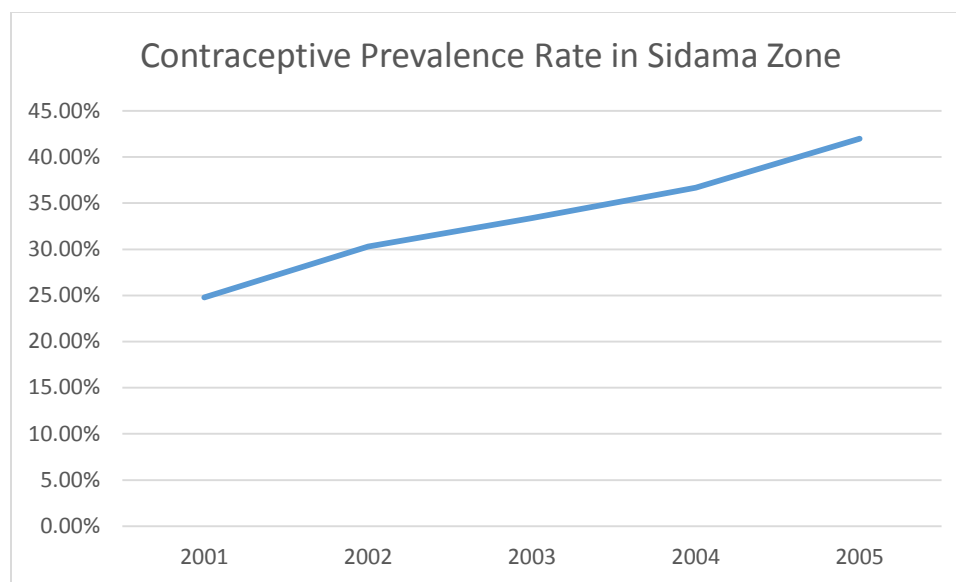


Fig. 9. Contraceptive Prevalence as Measured by the Proportion of Service User Women to the Eligible Women Multiplied by 100 in the last five years (2008/9-2012/13), Sidama Zone, SNNPR, Ethiopia.

Qualitative Results

How do women perceive the contribution of contraceptive utilization toward health and empowerment?

Women's experiences of contraceptive use: health benefits. Health benefits of contraceptive service use are well established in the reproductive health arena, but this understanding is not necessarily shared across all beneficiaries everywhere. Frequently missing are reports of women of reproductive age in rural areas in countries such as Ethiopia, where usage is relatively new. This study sought to learn the health related benefits of contraceptive use from the perception of the service users – specifically, women in the rural community of Sidama, SNNPR, Ethiopia.

Overall, women discussed the health related benefits by comparing their lives before and after the service use, and by comparing their lives with their mothers. Results clearly showed the multidimensional benefits of contraceptive use for both women and their children's health.

It was indicated that many factors have been affecting both women's and children's health. Women expressed their perceptions about their own health status before making use of contraceptive services, taking into account their reproductive affairs, nutrition, child care, hygiene, and marital relations, to mention but a few. All study participants consensually expressed that their pre-contraceptive health status was poor in many ways. Women's modern health service use was hampered due to their ignorance and absence of services in their vicinities. Rural women were far from modern health information and services. Consequently, they were exposed to the risks posed by harmful traditional practitioners in their localities or would simply wait for illnesses to play themselves out naturally. The right of women to make choices about their reproductive issues and on the number and timing of children in particular, was largely contingent on prevailing socio-economic and cultural arrangements.

Before contraceptive use:

A 25 year-old woman with five children who had used contraceptive services for three years put her pre-contraceptive use life like this:

Let me say something about my life before contraceptive use. I was forced to bear children very closely. I did not have enough to give for my children and I did not get

proper food during my puerperal⁶ time. I was badly affected by chronic nutritional problems and no desire for life including sex. (FGD 01 Dis # 8; P. 8, Para3 line 1-4)

A 25 year-old woman with four children who had used contraceptive service for ten years added her experience as:

Before this service use our lives were full of fear and challenge. You know... we were thinking of subsequent pregnancy immediately after birth. We wished to abandon it but it was not possible as long as we live with our husbands/men. (FGD 01 Dis # 2; P.2, Para 2; line 1-3).

As has been elucidated, these women's lives were spent trapped between being pregnant and caring for very young children. They have experienced much child illness and death, and quite often death resulted for mothers due to problems in pregnancy and childbirth. It was with deep sorrow that I listened to their accounts of being unable to offer proper care for their children. As they bore children on a yearly basis, they did not have enough time and resources to properly care for their children. They were forced to stop breast feeding a demanding young baby for the fear that if they continued to do so, the one in the womb would be affected. Most women believed that if a pregnant woman breast fed her young child, the milk may not be safe for the child and could compromise the growth of the fetus in the womb.

A 36 year-old woman shared her experience by stating:

When I gave births every year basis, I had no time to breast feed, provide balanced food and overall care. The subsequent pregnancies took place close and deprive necessary care to the older one. Due to such conditions, the children born these ways got sick frequently. I was emaciated as giving births yearly basis and keeping on breast feeding. (FGD 07 Dis #1).

A woman from the ninth FGD site similarly expressed her experience:

⁶ Puerperal is an equivalent term for the woman's expression 'aras/mechat' meaning the first forty five days after child birth.

I had nothing by the time when I gave that birth. I have nothing to give her to eat or to drink. My husband was the ex-soldier and we have no adequate resource. My daughter is pretty but due to our abject poverty we couldn't give her basic requirements.

Therefore, she was critically malnourished to the extent that her hair turned to grey like an old person. While I was unable to feed my first daughter in the aforementioned critical situation, I got pregnant again suddenly in a year time. Thus I was forced to stop breast feeding my first child despite her deep desire to continue it. She was crying very much when I prohibited her from breast feeding. My second child came soon after.

(FGD 09 Dis #5 p. 58, Par. 4, line 2-7)

Women's experiences regarding their personal care revealed that it had been highly undervalued, being unable to prioritize their own needs amongst so many competing factors amidst a lack of time and resources. As a result, they lived in unhygienic and poor conditions. They did not have enough water, soap, and basic time to wash their body and clothes. Their time was almost always occupied by being pregnant and or caring for very young children. The excrement of young children and spoiled breast milk residue on their clothing caused unpleasant odours, and it seemed that they were unable to care for themselves or their bodies, jostled from one thing to another to accomplish day-long domestic responsibilities.

A 35 year-old woman has shared her experience by stating:

We were unaware of ourselves before we use contraceptive methods. We had no time to clean ourselves. We have no time to think for ourselves. We were untidy; our body smells foully, children urine was all over our rags and bodies. We start ramifying in the morning to prepare breakfast, and then engage into our daily routines such as preparing lunch, fetching water, gathering fodder for cattle, cleaning cattle waste etc. Our day goes as we were swinging here and there. (FGD 01 Dis #1 p. 1 para. 1, line 1-5).

A 30 year in-depth interviewee woman from study site 03 added her experience with the same topic as:

If to put in a very simple way, before contraceptive service use, our lives were messy, untidy and full of bad odors. We were forced to pass our nights in bed richly soaked with children urine. (III #7 P.13, Para.7, line 1-3).

On top of all these and other challenges, these women experienced discord in their marital relations. Neither their husbands nor the surrounding society appreciates or sympathises with their burdens, but rather, disgraces them. Husbands easily move out looking for other wives who catch their eyes, as they no longer find their older wives attractive. These women are emaciated, untidy, weak, and overwhelmed with domestic duties and child care and as they state it, they have little time or will to please their husbands. Such circumstances create huge polygamous marriages in a society where husbands totally neglect their older wives or gave little time for visiting them. These conditions not only harm women in terms of resource sharing but also detract from their human rights and right to be treated as equals in marriage. One of the reasons for such problems in this community is that women in rural areas have little power to make their own decisions. They have no resources of their own to depend on. Their overall fate is depending on their husbands.

A woman from FGD site 02 has rightly mentioned her experience by indicating:

My husband was poor when he married me. Through the joint efforts I made him prosperous. He was protestant Christian before but when he got money and bought a car, he denied me and married to other wives in town. He felt that I am not matching him at this stage as he is educated and prosperous. He married to educated and prosperous women. He was from poor family but I made him prosperous leaving out all my privileges and begging my father to give me some money. I worked day and night to make him a full man. I never thought of my personal comfort and safety. I have invested all my time and resources on him but the final return has been a denial. (FGD 02 Dis # 4, P. 18, Para. 2. Line1 -7).

A thirty year-old uneducated woman from FGD site 03 expressed her experience in a similar manner:

When my husband married me, he had strong love. But when I started to give birth, he was keeping him distant from me. In past when I deliver, I was forced to stay away of our regular bed. Temporary bed is being prepared from the leaves of 'inset' 'hashuchcho' on ground. Due to baby's urine and uncleanliness, worms used to grow beneath us. (FGD 03 Dis #6 P. 24, Para. 4, line 1-5)

A quote from FGD site 04 discussant:

In the past, Sidama men marry up to seven wives. Some of the reasons for this were the older wives became untidy as caring for their young children. All their time were occupied with the care of children and gave little attention to their wellness as well as that of their husbands. Women's' lives were overwhelming where they have little time to take care of their cleanliness and remained unattractive to their husbands. Consequently, husbands were looked to marry new wives. (FGD 04 Dis # 8 P. 30, Para 4, line 2-6)

In similar way a 22 year-old woman from FGD site 06 has given her insight as:

In the past when we were untidy and contaminated with our children's urine and faeces thus, people disgraced and undermined us. Even our husbands did not care about us. They too, undermine and down look us. We were trapped in burdens of domestic work including child care. Our lives were totally engulfed by pregnancy and child bearing. (FGD 06 Dis # 3 P. 40, Para 3, line 1-4)

Closely spaced consecutive pregnancies and child births also depleted women of their nutritional reserves and deteriorated their overall health status. Women in the study have also experienced poor health in the past due to the inability to eat adequately and a lack of time to rest. Most of the time in rural communities, women's needs were subordinated to those of other family members in the house. They sadly expressed situations they experienced in the past, passing many nights with no or little food. Women were the last to eat, if they ate at all, after serving their husbands and children. Consequently, they were undernourished, sick looking, dizzy and desperate. They described totally disliking their lives and how they sometimes argued

with their God, asking why “He” had created them to lead such miserable lives. They felt highly dissatisfied and angry about their fate and that of their children. Their previous life experiences showed that they preferred dying than seeing their children’s suffering from malnutrition and frequent illness.

In connection to the above statements are the following points raised by a twenty-five year-old woman with seven children from FGD in site 03:

I had one difficult labour which had threatened my life. If I had not started contraceptive method use, I would have died this time due to pregnancy related problems. Thus, above all contraceptive has saved my life. During the difficult labour what I faced was retained placenta. Nobody has taken me to health institution. The retained placenta expelled by itself the second day and bleed massively. That has clicked me to be on contraceptive for fear that subsequent pregnancy would carry more risk. I know similar incident which had ended in life loss. (FGD 03 Dis # 4 P. 20 Para 4, Line 3-7)

A 28 year-old woman from FGD site 04 expressed similar concerns:

We had no time to take care of ourselves before this service. We hardly clean ourselves. We eat little as we have to give priority to our husbands, children and we were the last to take our share if we could access after all. Former life was untidy both for us and our children. We barely provide enough food for our many children. (FGD 04 Dis #1 P. 27, Para. 1, line 2-6)

Another area related to women’s reproductive health is poor marital relations. They commonly experience quarrelsome nights with their husbands. When night fell, they hated it, as they knew the request of their husbands was coming. Some of them mentioned that they could hardly remember having had sexual relations with their husbands joyfully. They said that the sexual feelings of a person depend on how one’s body is physically and psychologically prepared. When hungry and tired, how could they think of sex? Instead, what comes to her mind is what to give her children the next morning, and how to handle domestic duties in an orderly and timely manner. But their husbands’ thinking was different than theirs. Husbands have the

upper- hand in resource control and overall power. They eat and drink well as compared to their wives and are often desirous of sex when the night comes. Women were not in position to deny their husbands' requests despite their deep disinterest.

A discussant in one of the FGDs put her experience this way:

However, my husband always urges me to have sex with him. When he comes to me I move out. I have no desire as my body was emaciated, from having no good food at that particular day. Men need women more than food for being women (sexual affairs). The reason is that after eating well he needs sex at night. If this fails to happen or I refuse to meet with him that night, he withholds the money to buy food for two to three days.

Another of the reasons why women disliked sexual relations with their husbands was the fear of becoming pregnant. They knew that they have not enough to serve older children and care for other family members, that and having more children would mean more challenges for them. However, their husbands were totally non- supportive of this concern and forced them to have even more children despite the consequences.

After contraceptive use:

Study participants collectively expressed their positive feelings towards contraceptive benefits in relation to their health and that of their children. They clearly stipulated the benefits of contraceptive use to many dimensions of their lives. They said that the majority of problems discussed previously in this study have been resolved by the use of contraception. First and foremost, they joyfully expressed that they are able to plan pregnancy and postpone it to the time they want. They revealed that unplanned pregnancies have been the causes for the many maternal and child health problems described above. Planning their pregnancies allows the women adequate time to care for themselves and their children.

A twenty-five year-old woman with five children from FGD 04 expressed her experience:

After we used contraceptive methods, a woman spaced her pregnancies, maintained her cleanliness, put on fragrant ointments, cosmetics and perfume, eat well and built her body, has good mattress thus pass her time with her husband in bed properly. Now we understood why our men married to seven and more as the one in the house looked

wildish, unattractive and skinny, as result swing their eyes to outsiders. Today we give time to ourselves and our husbands receive our contraceptives on time and avoided unwanted pregnancy, thereby we live peaceful and lovely lives. (FGD 04 Dis#7 p. 31, para.2, line 3-8).

The women in the study also mentioned that from the time they started using contraceptive services, they became clean, hygienic and maintained their personal appearances. They have changed their image in the society from a previously untidy, foul-smelling state to one that is pleasant and attractive. Contraceptive service use has improved their knowledge of other health related issues such as vaccination, growth monitoring, HIV and AIDS, ANC, prevention of harmful traditional practices, etc. Their knowledge of other health services was improved through the integrated health service delivery approaches. When they visit the health post for contraceptive service, they also get information from the health extension workers about the other packages of the health extension program. Women also mentioned their ability to access health services in their nearby *kebele*. They said that at this time, every *kebele* has its own health post where women access health services such as contraceptive methods. As a result their health related knowledge has improved.

In connection to this, a young woman with four children from FGD site 05 gave her insight towards her experience:

Since the inception of contraceptive service use, we, women have been able to space pregnancies and delay childbirth. We keep our personal hygiene and that of our children. There is no as such foully smelling like the previous time and our husbands are not distancing themselves from us. Now the woman appears attractive and neat that a man is also motivated to have good sexual relation with her. We, the women also desire sex when we eat well and feel healthy. But we don't want to have sexual relation when our body is emaciated. Husbands are also selective in this regard as they do not want to approach us when we are unclean, emaciated and clumsy. Contraceptive use has created

golden chances for us to avoid undesired pregnancies; hence our body weight, makeup and appearance seem well. (FGD 05 Dis#3 P. 37, para. 5, line 4-8)

A quotation from a woman from study site 06 affirms this account:

But after the introduction of contraceptive services in our locality, women are able to bear children in spaced and planned manner. The older child was grown before the subsequent one comes. He/ she reached to the stage of walking, running and playing with neighbour children before their younger born. We have got adequate rest between pregnancies; the amount of bleeding during labour has become normalized. We feel healthy, stronger physically, and knowledgeable about various issues including reproductive health. While receiving contraceptive service we have also acquired better awareness and skills and how to care for our children in terms of complementary feeding, providing balanced diet from various sources, their hygiene. Both our mothers time and in our time before contraceptive service use, we had no exposure about proper children feeding practices. (FGD 06 Dis # 2 P.39, para.3, line 6-13.)

Because of an ability to plan pregnancy and control the time between pregnancies, the women who participated in this study report eating relatively well and having improved physically. The changes in their physical health status are apparent in many ways. During the times in which they gave birth on a yearly basis and lacked enough to eat, they were highly emaciated. As a result, they considered themselves so light that even a wind could easily lift them up. Since using contraception and being able to space their pregnancies, they have had the chance to properly nourish themselves and now feel their weight to be standard. They expressed that when walking, they now put their legs down with enough force that they could hear the sound of their steps on the ground.

The women who participated in the study also stated that since they began to use contraceptive services, they feel free and peaceful psychologically. Contraceptive service use has alleviated their worries related to frequent pregnancies. They also considered themselves most fortunate to receive the service in order to control time between pregnancies. The women

explained this sense of good fortune by comparing the quality of their lives before and after using contraceptive services. Contraceptive use has not only improved their health status, but averted premature maternal and child deaths. In connection to this, they explained how they had lost either their mothers or sisters due to problems related to unregulated pregnancies and child births. With these losses in mind, the women expressed how fortunate they are to see this bright day, and are able to enjoy the benefits of contraception.

A 25 year-old lady who used contraceptive service for four years, from FGD site 03 explained her lived experience of how she has benefited from the service:

I know of similar incident which had ended in life loss. My husband's sister was died in similar condition. They took her to Yirgalem hospital after long delay with retained placenta but on her arrival at hospital, she lost her life. You see, God has brought this service to avert such premature death of mothers. I really understand that we have got many benefits and averted maternal death that may occur as a result of unwanted pregnancies. (FGD 03 Dis #4 P 20, para. 4, line the last 5 lines of the paragraph)

Study participants reported on the improvement of their children's health status following the mother's use of contraceptive services. Children born after service use are doing very well both in their physical growth and mental development. The mothers are now able to breast feed their children for at least for two years and are able to give them better care. The participants have recognized that when the number of children is a small or manageable size, and the proportions of shared food are adequate. The women mentioned children born after service use are stronger, and doing very well while playing, studying, and working. Moreover, it was expressed that they have established better bonding with their children as they have more time to spend with them.

A study participant from FGD 09 has elucidated her experience with regard to children health after contraceptive use in the following manner:

Children born after contraceptive use have got better care than their older brothers and sisters. The older children had frequently affected in many diseases. I took them to health institutions many times. The two children born after contraceptive use are

healthier and stronger. They had never been affected by any noticeable disease. They have received recommended vaccinations and received certificate for their accomplishment from the health post. (FGD 09 Dis # 1 P. 57. Para. 2, line: five lines from the end)

During pre-contraceptive use, women were forced to visit the health institution very frequently to seek medical help for sick children. Since using contraception, they only visit for vaccinations and growth monitoring. Their quarrel with their Lord has changed to thanks for what they have received. The reason is because they have seen that their children are growing very well, they have more time to care for them, and they are freed from worries related to having unplanned pregnancies and young babies.

One discussant woman from FGD site 06 has clearly explained her experience:

What I want to tell you is that I have six children already. I gave three births before I started using contraceptive service and three after I started the use. I did so as I recognized that if I use a service I can plan when to become pregnant. Accordingly I have managed to postpone pregnancies after using the services. When you have space between pregnancies, you really love your children and become eager to see them. When you get rest between pregnancy means you get comfort both physically and mentally. You use your mind to think deeply how to overcome life challenges and set means to generate your own income. (FGD 06 Dis #3 P. 40, para. 2, line 1-7)

Improvement in their marital relations was another area elucidated by the women who participated in the study. During the time when they were overwhelmed with many young babies and their related demands, the women frequently denied sharing linen with their husbands in bed. They said that thanks to the Lord and the government, they are now truly exercising their womanhood and feelings. When their bodies get adequate rest, and when they feel mentally free and at peace, not only do they please their husbands' desire, but also enjoy their own natural sexual desires.

A thirty year-old woman has elaborated experience of the issue:

With respect to sexual desire and feeling, I have no problem. Before contraceptive use I fear sexual relation with my husband for unwanted and mistimed pregnancy. Now nothing as such will frustrate me as I am able to protect unwanted pregnancy. We share all our feelings each other. I have a desire as a human being that has to be fulfilled. I feel joyful with regard to sexual intercourse this time. In order to satisfy each other, we discuss the sexual matter like any other household issue together. Contraceptive service has improved our health status. We better feed and take good care of ourselves in terms of hygiene and feeding. I have good feeling now as similar to the time I have married. (FGD 07 Dis#3 P. 49, para. 1, line 1-7)

Some of the women who participated in the study have mentioned that they have been able to win back the heart of their husbands who had previously left them during their poverty and weakness. They are capable of attracting their husbands and catching their eye. Husbands who had left their overburdened wives now came back as they saw changes on their wives' appearances. Women expressed their deep feelings about the benefits of contraceptive use by indicating that they are really emancipated from the intrusions of unplanned pregnancies.

A discussant from FGD site 02 also elaborated the change in her marital relations and sexual life:

I reminded days back when I said no to sex to my husband. I think the reason for his new marriage was my unresponsiveness to his sexual request. The day came to me and now I face over feeling. So, where to get him? When he visits once every week, he understands that my feeling is highly improved. He says, you are really changed since started using contraceptive methods. He also says to, "now you are my best" and I say him keep quiet, I say to him, "you behave as urbanized man" indicating that I was abashed. I have better sexual desire than before and when my husband asks I say to him I became better in this regard than you who is well fed and looks strong physically. I need more but his absence from my home for a week discourages me. (FGD 02 Dis #7 P. 18, para.7, line 9-16)

Another quote from a 30 year-old woman who used contraceptive service for eight years from FGD site 08 is presented below:

Before contraceptive service availability and its use, we hated male. We had no good environment to think about what sexual feeling is. Our lives were tapped by many domestic work burden and demanding children care. As I said, we were not in position to care for ourselves and undermined our personhood. Therefore, we departed ourselves from our husbands. We lived in full of conflicting situation as our husbands urged to have sex but we denied their requests. As a result husbands were forced to look to other wives to feel their desire. The situation is now different. We use contraceptive service and share bedding with our husbands. We have no fear of unwanted pregnancy that hampers us from having sex. I am convinced to share my time with my husband in this affair. I don't want to annoy him and to hide my feeling this time like the previous time. (FGD 08 Dis #7 P. 54, para. 5, line 1-9)

Women's perception of contraceptive use: benefits toward empowerment

Economic empowerment. This next section discusses how the benefits of contraceptive use were perceived by women who participated in the study in terms of economic empowerment. The researchers discussed the livelihoods of the women and their families in relation to contraceptive service use (before and after service use), whether there were any changes experienced and how the women perceived the changes related to contraceptive use in their lives. Study participants explained their experiences in detail.

Before contraceptive use:

Study participants collectively expressed that their livelihood situations in general were poor before contraceptive service use. The majority of the study participants mentioned that they were uncertain about their lives and livelihoods. One of the main reasons for the uncertainty was their inability to control their fertility. They expressed their overall status as being poor and living substandard lives due to being pregnant or lactating young babies. Women were not in a position to control their reproduction and be involved in economic production. Rather, reproduction has controlled their lives by trapping them in a tight domestic environment. All

their time was occupied in domestic duties including child care. Overall, study participants explained feeling desperate about their livelihoods and poverty before contraceptive use with a sense of deep sorrow and regret.

In connection to the expressed concerns about a lack of time, some excerpts from the participants are presented below:

Before the time of contraceptive use most of my time was occupied in pregnancy and child care. I had many domestic responsibilities such as preparing food, fetching water, collecting fire woods, caring for children and also support my husband in agricultural fieldwork. These responsibilities usually doubled when I become pregnant and bear child. (III # 1, site 02)

Life before contraceptive use was occupied by frequent pregnancies and child births. I almost bear yearly basis. After I started using contraceptive method, I saw changes.

When I say a change, as I said earlier before contraceptive use I gave births year by year and all my time was occupied by pregnancies and child care. (III # 18, site 09)

Let me first tell you about the process and consequences of pregnancy and child birth.

Pregnancy ruins your physical strength. When you are pregnant, it is difficult for you to act in the manner that you are not pregnant. It limits your capacity to engage in various activities such as generating income. (III #2 site 01)

A woman both during her pregnancy and lactating period hardly has time to move out of her house or to become involved in income generating activities. When the number of children increases due to uncontrolled fertility, the family plunges into abject poverty. The reason is straight-forward enough: only the husband acts as a bread-winner, whereas a wife/woman is kept home for domestic activities. All others are dependent on the limited resources and the individual share gets further diminished. Related to this is the concern of land size in rural communities. All livelihoods are based on agricultural activities where arable land is the main means of subsistence. However, household land size is alarmingly reduced where the quality and quantity of productivity is correspondingly diminishing. Thus, unregulated fertility at the

household level has been one of the main causes for life deterioration, and this in turn leads to abject poverty. A woman from FGD site 06 shared her experience:

“When the number of children is more, there is little or no food to eat and poverty is at your door” (FGD 06 Dis #2).

“Before contraceptive use, we mostly experienced to have closely born children one after the other. I used to carry one on my lap and the other on my hands at the same time.”

(FGD 07 Dis #4)

Lack of action to mitigate such deteriorating livelihood situations has led parents keeping children out of school as they are unable to afford their school materials and feed them. At the same time older female daughters were expected to care for younger children and help their mothers in domestic activities. Women also mentioned that economic problems in the family not only hamper the fulfillment of household demands at present but is also an obstacle for future human capital development. When understood in light of these facts, contraceptive service is considered as an emancipatory tool or liberator for women, while the past is equated with being held captive to unplanned and unwanted pregnancies. A woman from one of the FGDs shared her feeling about the service:

If we had this service some times in the past, we would never be troubled and challenged with life misery. We feel happy as we lived in this service for short time. If we had chances to be used the service in long past, I can imagine how much our lives could have been transformed. I surely say that had we used the service earlier than this time, we would grow, prosperous, and healthier (steps higher). (FGD 09, Dis # 9)

I said to them that, yes you are right. I am too young to have this numbers of children but as I have no education and awareness about what to be done, I ended up here. Before contraceptive use I was like a prisoned person. I couldn't go anywhere out of my house. (FGD 08 Dis #6).

After contraceptive use:

Women expressed that after the start of contraceptive service use, their livelihoods have improved in different ways. These improvements are expressed in many aspects of women's lives. They explicated the mechanism by which contraceptive service use helped to improve their livelihood and income at the household level. Primarily, the gains made were in time, energy, and engagements.

By the time when I gave births to many children in close gaps, I was unable to go to market. After I have started using this method, I am not waiting my husband's hand only. I grow vegetable in my garden such as cabbage and others. I sell some part of these and earn some money and use to eat part of these. (FGD 04 Dis # 7)

When women are able to postpone unwanted pregnancies and child births, they have more time to plan and engage in non- reproductive issues such as income generation. Pregnancy and caring for young babies are not only time consuming, but also weaken the strength of women and pull them away from engaging in economic activities. Women who participated in the study did mention that when they get freedom from unplanned pregnancies, they started to become involved in various income generating activities. Some of them are involved in small scale merchandise, buying items from relatively distant markets and then re-selling these items in their local market. By doing so, they make some profit out of the exchange and transaction.

Now I am a merchant working partly in the market. I have no worries like previous time as there is no young child who needs my frequent visit. I send older children to school and then work whatever I can do. Contraceptive use has enabled most of us to engage in diverse income generating activities. Some of us became owner of better houses, others bought cattle. We were totally dependent on our husbands formerly because our times were occupied in child births and related subsequent care. Now we are in position to handle our revenue that has given freedom of decision to mobilize our resources to expenses at our level. (FGD 02, Dis #2)

Some other women are involved in backyard vegetable cultivation where they grow vegetables such as cabbage, onion, tomato and others, and then sell at the local markets. By

doing so, they have been boosting their household income. Moreover, women said that they also had more time to help their husbands in agricultural field work on top of their domestic responsibilities.

Some of the study participant women who shared their experiences of engaging in income generating activities as a result of increased personal time have been involved in labour work, such as in coffee processing plants. They worked as daily laborers and were able to earn a salary because they were not occupied being pregnant or caring for a young baby at home. When they engaged in such labour work, they perform it peacefully and efficiently. Others have been involved in cattle herding and generate income by selling dairy products, poultry, calves, beef and cows when they have a surplus.

I have small plot of land which is also not fertile. What I have done since I started using contraceptive service is that I herd cattle, sell some and earn money out of them. You see, herding cattle is labour intensive. You have to prepare fodder for them. To do so, you have to have enough time. Contraceptive use has averted unwanted pregnancy for me and I am free to use this time for collecting fodder for my cattle. I also sent my children to school. One is grade eight, the next one is grade seven, and the third one is grade six. I am also determined to send all my children to school as I know that unless they get educated they will burden for me. I have no enough land and my rudimentary agricultural activities cannot bear them in the future. (FGD 08 Dis # 1)

Other women who have participated in the study have reported that since having more personal time as a result of using contraceptives, they have engaged in credit unions, thereby becoming involved in some investment enterprises. They are able to construct better houses or change their previous grass roof with an iron sheet roof, send their children to school, buy better clothes for their family members and improve the overall status of women. These women have applauded their experience of pregnancy planning for having created wonderful opportunities to improve their income and position in the community. They joyfully expressed that they are now considered the pride of their husbands.

Now I do my work. I have poultry and garden cultivation where I work most of my times. The freedom has created wonderful opportunities for me to involve in income generating activities and use the income to manage my house properly. I am now considered as a grace for my husband who abandoned me and my children by the time we were in miserable life. (FGD 02 Dis #5).

It is six years since I have started using contraceptive services. For example, during the winter I work in coffee processing site and I also prepare '*injera*'⁷ for various social ceremonies. I am paid for these services and earn money. By doing so since 2006/7, I was organized in the credit and saving association and saved some money. I received some money from the association for house construction. My house is now upgraded from grass roofed to corrugated iron sheet cover. I live a decent life with dignity now and considered humanely both within my family and in my community. (FGD 06, Dis #6)

Therefore, I have no big worry about unplanned pregnancies and able to participate in income generating activities other than domestic responsibilities. I merchandise coffee and earn some money. I bought sheep, goats and chicken, fatten them and sell to get money. This time we are building big house and I have given some money I got in such process to my husband for construction expenses. (FGD 08 Dis # 7)

Another amazing point learned from women's experience is that they are not only generating income but contraceptive service availability and use have helped them to plan how to expend household income with proper order of priorities and significantly minimized wastage. When the number of children is large, resources are mismanaged. Sidama Zone is known for coffee plantations, and during the coffee season all household members take the coffee to market by various routes for sale. When coffee bean ripe on a tree, it is easily accessible to every member of a household to collect and take to market. Lack of proper mechanisms to control

⁷ '*Injera*' is a flat and tiny bread made up of a flour of local grain called '*teff*'. *Injera* is a staple food of Ethiopia.

expenses through multiple routes in a family greatly affected the household savings. `However, study participants agreed that family planning helps proper resource management at household and community levels.

In the grace of our Lord and due to the commitment of the government, now we are freed from challenges related to mistimed and unplanned pregnancies and their related burdens. We are now capable of taking our level actions either to generate or expend income for minor household activities. Therefore, we are saved/freed from looking hands of someone and started to exercise our rights and autonomy. Simultaneously, we learnt how to use our resources in economic way. We relate all these to contraceptive use as it averted unwanted pregnancies and created opportunities to properly use our times. We have no as such worries about cries of young children. Our minds and hearts are cool and restful now. (FGD 02 Dis #3)

Further, study participants have elaborated that contraceptive service use has helped them improve their working culture both in their family and the community. By spacing pregnancies, a woman becomes healthy and free to involve herself in outdoor activities. Her capacity to work in various sectors improves, which includes supporting her husband in the field and directly working for herself. This increases productivity in the field and raises household income.

A thirty year-old woman who used contraceptives for five years has expressed her experience of the economic benefits of contraceptive use by saying:

I have got numerous livelihood improvements since I started using contraceptive methods. I saw many pleasant things. With regard to involvement in income generating activities, I equally involve in agricultural production. When my husband produces one quintal, I do the same. I sent one of my sons to Hawassa to attend his school there. If I am pregnant, I cannot do this. I do many things, produce many things and sell them to boost my income level. All these have been materialised because I have in contraceptive use and averted unwanted pregnancies. (FGD 04 Dis #6)

Contraceptive method use helped me to avoid unwanted pregnancy there by created time and energy for engaging in various outdoor activities thereby generates income for my household use. Moreover contraceptive use has enabled me to help my husband in various outdoor works. We have now more cattle, chickens better crop productions. My husband works in pleasant way than before. We have constructed better house as compared to the previous time. When taking these all into account, our livelihood has tremendously improved. (III #2, site 02)

However, a few of the women involved in the study mentioned that they have difficulty in ascertaining whether or not their livelihood has changed. The economic status of these women is highly fragile and they are sometimes unable to differentiate their status before and after contraceptive use. Livelihood situations vary across the study districts. Boricha district is identified as one of the areas of the Zone with the least potential for development and has been liable for many social-economic challenges. This is substantiated by the district health manager in his explanation of the importance of demographic and economic rationales of contraceptive service provision.

Our livelihood is problematic. We have critical food shortage in our house. We purchase on daily base as we got money to do so. The reason is that we have very small plot of land to be cultivated. Our livelihood was mainly dependent on what we got from our small portion of land and engagement in trading. The trading part had been supported us in the past but this year it did not work. I can say that our livelihood is just on the mercy of our Lord. It is difficult to reveal whether contraceptive use has contributed to the improvement of our family economic status or not because of our poor basis. But, what I cannot deny is if I hadn't been on contraceptive method, our status would have been further deteriorated than this (III #6 site 06)

Educational empowerment. The study also addressed educational dimensions of women's empowerment, exploring lived experiences with respect to their own and their children's educational attainment; the emphasis was on their daughter's education. The intent was to elucidate how they relate contraceptive service use to education processes.

Study participants again expressed the benefits and contributions of contraceptive services use in a before-and-after perspective. They also considered education during their mothers' time; noting that for most of the past there simply was no access to contraceptive services. They also explained how education in general and female education in particular had many challenges in their context. Notably, they mentioned that because of the underlying conservative culture and traditions, female education has been greatly jeopardized.

A discussant from site 02 suggested:

Now things are different than before. With regard to contraceptive use related experience to female education, we are sending our female children to school. Moreover, we ourselves are continuing our education as we have time to do so. Our mothers brought us up in the manner they were brought up. They lived all their lives with many challenges and brought up us through those challenges. Now we should not repeat the same upon our daughters. Now we are cognizant to teach our children including our daughters. Their future will depend on what we invest today upon them. They have to be in better position than us. Our mothers did all that as they did not have means to delay unwanted pregnancies. Now we have opportunity to do so and use this to enhance chances for our daughters. (FGD 02 Dis #2).

I was attending school before my marriage. I attended up to grade five when I was forced to stop my schooling due to marriage by abduction. Since then, I haven't got opportunity to continue my schooling. (III # 1, site 02)

Sidama culture did not favour female education by considering that "the best education for a female is mastering domestic work" as stated by one of the discussants from FGD 01. They

strongly believed that once a girl experiences how to handle domestic works in a proper manner through helping her mother, they feel that she is mature enough to get married. They force a girl to engage in early marriage by stating that “let a girl and ‘dead body’ leave the house timely”. It is a heart breaking and touching issue; how women’s lives were curtailed due to conservative tradition and patriarchal dominance. Women with all their relentless efforts day and night have been considered as sub-human or unimportant. This was how the vicious cycle of women’s oppression continued and revealed that older women were part of the cycle of oppression of younger women or their girls.

One quite interesting quote from FGD site 05:

In the past including myself, our parents said to us that female education is meant to equip her how to handle her house. She has to be competent in domestic work and how to handle her house. They said how on the earth a female goes outside. They harmed us in keeping us away from schooling. I am illiterate and end up in marriage. The reason was that my mother didn’t know the benefit of female education and didn’t send me to school. We had no capacity to say no to their decisions. They were saying no female education; “female and dead body should leave the house as early as possible” (ሴት ልጅና ፊሳ በጊዜ መውጣት አለበት), consequently ended up in early marriage. (FGD 05 Dis # 4)

With respect to my educational status, I had never attended schooling. My parents did not give me such opportunity. Our childhood life was blurred/dark time where many of our parents had no courageous or belief about female education. Like most of my age female children then, I remained illiterate. (III #13, site 04)

Beyond the underlying cultural and traditional thinking, female education is hampered by other factors related to maternal fertility. When a mother bears children in unregulated/ closed gaps, an older daughter is forced to stay home to care for her younger brothers/ and sisters and is a puerperal mother. In the near past, older female children did not typically attend school or were pulled out if they had already started schooling with the intention to help her mother in domestic works. A woman from study site 04 mentioned her experience as:

I made my daughter discontinue her school for one year when I gave birth. She cried as she was forced to quit her schooling. Her friends came to me and complained on her friend's situation. I promised for my daughter and her friends not to repeat the same mistake, even if I bear twins. (FGD 04 Dis #2)

The unregulated fertility of parents is one of the major obstacles for children receiving schooling, with a major impact on females. The over-stretched tiny rural household economy is not capable of accommodating children's schooling and other related expenses. If parents desire to prioritize a limited number of children for schooling, the female barely gets the chance. They are the first to be enrolled in domestic activities in support of their mothers. An excerpt from a discussant from study site 08 strengthens this idea:

Yes, in the past for two reasons (either total absence of contraceptive service or lack of proper information about it) our parent gave births to more than 10 to 12 children.

During that time they never encouraged to send their female children to school as they want her to help in domestic work. They said 'what education' as we are being overburdened here with nonstop pregnancies and child births. They pulled us back from our education to care for younger children and help in other domestic work. (FGD 08 Dis # 5)

Another issue the study participants shared in their experiences related to challenges to female education has been school dropout for early marriage. Significant numbers of their girls stop schooling and end up in early marriages without the knowledge of their parents. Some mothers desperately explained their bad experiences as their daughters ended up in marriage despite their strong will to see their educational fruits in the future. The young girls are influenced by some local marriage agents and peers that suggest that getting by a better dowry, they will lead a better life instead of staying in school for a long time. They thought that marriage is the shortest path to lead a better life as compared to spending the time in school. Here it is worth mentioning that the underlying parental poverty has been among the push factors

for the young girls' lack of education or school dropouts. Here is one of the elaborative quotes from the individual interviews:

I send my children to school. I believe that education is one of the important instruments shaping the future of our children. Out of five children I have; three are females. My older daughter was in school but she has dropped it for marriage without my knowledge. They fooled her and took her for marriage. I was totally in disagreement about that marriage but lacked strength to put an end on the marriage. This very young daughter was ended up in such an untimely marriage because they fooled her by telling her they would give us huge money in terms of dowry. One of the problems in our local culture with respect to marriage is the involvement of outsiders. Those brokers without the knowledge of parents cheat young girls. That was how I lost my daughter. I would never let her marry at this age. My plan was to educate her to the level I could do. (III #7 site 03)

Study participants have elaborated on the change in educational status in their family since they have started using contraceptive service. Contraceptive service use has helped the women to plan pregnancies and avoid unplanned/unwanted pregnancies. They have explained how unregulated fertility hampered educational attainment and how averting unplanned pregnancies means having more time and the capacity to engage in non-reproductive activities such as education. Being free from pregnancy means being able to move freely or “fly” where ever they want; be it to school, market, social gatherings, health institutions, etc.

Women mentioned that they are cognizant about the benefits of education to their children's future. Some of them said that they have no other means to provide for the future other than investing in education. Since the household land size has critically reduced, they do not have enough plots to share in the future. Women become cognizant that helping their children to work well in school paves a way for their future livelihoods. With this intention, women allow their children (both male and female) to attend school.

In connection to this explanation it is worth citing the following quotes from participants directly:

I see education for my children as a sole means to escape livelihood challenges and springboard for future prospects. With this intention I am greatly determined in sending all my children to school. At this time three of my children are in school.I give more emphasis to my daughters. I have got enough lessons from my sufferings. ‘What do you talk about?’ Had I been well educated, I would never lead a life like this. As a result, I am highly motivated to educate my daughters with particular emphasis. I feel I lagged back in many directions (economically, intellectually and socially) for the reason that I haven’t succeeded in my educational career. This is why I show great commitment to my female children/daughters and curious to see when they attain high level career (III #2, site 02)

The very purpose to start contraceptive use is my recognition to the ever changing livelihood situations particularly shortage of land. You see, unlike the past times now a days land holding capacity at house hold level is rapidly diminishing. I have five children (three males and two females). I have decided that these five children are adequate for me as the current situation is taken into account. (III #5, site 06)

Some of the women who participated in the study reached the level where they discussed their children’s education issues at a family level, most importantly with their husbands, and decided to send them to school. Contraceptive service use has helped them to have more time to effectively handle their domestic work alone and to send their children to school. Service use has contributed to girls being able to attend school rather than caring for young children and their mothers in post-delivery.

Women also explained that, because they are not pregnant as often they have time they go out to market, to be involved in trading, and to generate some money to invest in their children’s education. Some women generate better income and fulfill their children’s school

inputs on their own without asking their husbands. Moreover, the extra time they have has helped them to follow their children school performances, to help them to study, and to help them with their homework.

Remarkably, study participants have mentioned that contraceptive service use did not only help in their children's education but also enabled some of the dropouts to resume schooling. Some of the study participants dropped out their schooling sometime in the past due to forced marriage. They were waiting for the right conditions to continue their schooling. They said that with contraceptive use, the time has come for them to continue their schooling. Some of them have completed their secondary school, studied at the college level and have become employed in professional jobs. They whole-heartedly expressed their joys in this regard and they are also able not only to send their children to school, but choose better schools. To this extent, some of them sent their children to urban areas where they feel that their children could get better education and will become more competent. It is here that their dream to invest in their children's future development starts taking shape. The following excerpt richly expresses this notion:

I gave birth to the second child after his older child reached grade nine. After that I continued my education and completed diploma before giving birth to my third child.

What helped me is a contraceptive method. I could have given birth to six to seven children if there hadn't been contraceptive service. There are women with such happenings. If I hadn't used contraceptive method, my education would have remained at grade 8 where I stopped during my marriage. I thank both my Lord and the government who have given us the opportunity. I also became able to be employed at public sector. (FGD 02 Dis # 9)

The study also revealed the experiences of some women where they had wonderful occasions to communicate with their husbands and plan on their education. Since contraceptive service use, they have been able to plan household education by setting a schedule for the education of both husband and wife. In one case, a husband proposed to his wife that he wanted to complete his education, from which he had dropped out in grade 9. He concomitantly

promised to make his wife continue in her own education following the completion of his own educational goals. This situation has been created in the family due to their ability to plan their family.

I have also great desire and plan to continue schooling myself. I wait until my husband completes his schooling, then I will continue. This time, my husband is attending his school. Therefore, I am unable to attend as if both we leave our houses, no one will take care of our daughter and domestic responsibilities. (III #4, site 06)

Physical (movement) and psychological empowerment including decision-making.

Empowerment is also related to psychological well-being, physical movement, decision-making, and relational aspects. Results as to that level of empowerment follow.

Psychological dimension. Almost all the benefits and drawbacks related to contraceptive use were again expressed when taking into account the experiences of women before and after contraceptive use. There was a clear relation between one's ability to plan pregnancies and establishing psychological stability or mental peace.

When a woman could not regulate her fertility, she had children in very close succession. This creates increased burdens on the woman both physically, psychologically, and socially. Such a woman cannot properly care for herself, her children, and husband. Lack of proper care for children may lead to malnutrition, illness and in the worst case, the death of a child. Similarly, repeated pregnancies and child births put a woman under increased physical strain. She gets physically exhausted, weak and continuously sick. Some excerpts from the participants are:

Our lives were about pregnancies and child births. One comes just after the other in nine-to-ten months' time. That was the time which we hated ourselves and our children. They were emaciated, not thriving well and not attractive to see. We ourselves were not well-fed, hygienic and undernourished. (FGD 02 Dis # 1)

Moreover, the body weight and physical appearance of the women deteriorates. All the problems put her in increased mental stress, and lacking the means to think for herself, she reaches to the level of considering herself subhuman. In such a situation, she dislikes herself,

loses interest in her marriage; develops feeling of disinterest in her future. When the situation becomes unbearable, a woman reaches to the extent of quarrelling with her Lord by saying why has He created her to be in such a disgusting life situation. This is undoubtedly understandable when considering how much excruciating experiences a woman faced. In Ethiopia, rural women in general are full of the fear of their Lord and never dare to raise strong words up against their Lord. But, the experiences described above shows the pressure of the problems faced by women as well as their lack of means.

When we see things in comparison (the time before contraceptive use), we were tight in all our lives. We carry new pregnancy in our wombs and breast feed the elder young children. Thus, we were bitterly disappointed in our God for our misfortune lives. (FGD 01 Dis #2 line 6-9)

You can imagine how demanding it was. I used to carry my new born where I did the work. I put him near my working place. When I did that I was also thinking of those whom I left at home. I was worried about what had happened to them. I was hanged over two poles; to get something for them to eat and leaving them alone at house. (FGD 01 Dis #4)

Women said that they had no means to escape from the vicious cycles of poverty, illness, and conflict in their relations; therefore, they became depressed about their lives. In addition, their marital relations are highly jeopardized by a lack of adequate time and means to please their husbands. They want to keep themselves distant from their husbands for fear that their relations would end in unregulated fertilities. When they behave in such ways, their husbands either want to assault them, or look for other women. Such situations have created weak marital relationships with their husbands and traumatized women psychologically.

I was forced to bear children very closely. I did not have enough to give for my children and I did not get proper food during my puerperal time. I was badly affected by chronic nutritional problems and no desire for life including sex. However, my husband always

urges me to have sex with him. When he comes to me I move out. I have no desire as my body was emaciated, no good food at that particular day. (FGD 01 Dis #8)

Study participants discussed their experiences related to their psychological status after contraceptive use and the change is clear. First and foremost contraceptive service use has created wonderful opportunities for women to either postpone or delay unwanted/unplanned pregnancies/childbirths. This in turn has created more time for them to give adequate care for their children, their husbands, and themselves. As a result they get a sense of peace and stability in their lives. Instead of the bitter and desperate feeling they exhibited, they become thankful to the Lord, and to the government and service providers. They considered themselves as most fortunate people by comparing their improved status to that of their mothers at a similar age:

First of all I want to praise our Lord for the availability of this service in our vicinities.

Next, I also thank the government for giving us this opportunity. We have got many benefits from contraceptive services. Before contraceptive service we mostly give two births within two years. This service has greatly helped in improving our livelihood and our family's. All my children are now attending school. I used to give breast feed only for 8 months before contraceptive use but now I give three to four years. We live as we plan these days in the era of contraceptive method. (FGD 04 dis #5)

I feel very happy (effoy⁸). I feel so because, I am free from the burden of pregnancy, no fear about the unlikely outcomes of it and have time to share for other activities than only the child care. My husband is too. I take the service in agreement with him. I told him about the benefits of the service and he whole heartily supported the idea. In general, I have pleasant feeling about contraceptive services as it has many help for a woman like me, for children and community in one way or another. I so far accepted contraceptive service in its positive outcomes. (III #14 site 08, Para. 6, seven lines from the end)

⁸ 'Effoy' is an Amharic vernacular equivalent to the expression of high level psychological comfort by removing challenges or distressing situations

In addition, they explained that their shadowed feelings of the old days had been converted into the bright shining days. They had now reached a point where they could take the time to breathe deeply and slowly and take some rest in their lives. Their prior feelings of disinterest and shame of themselves have transformed to pride and good fortune, as if they had the most privilege and opportunity. They speak of reaching the level of considering themselves as fully human – as a person that can stand before anyone without fear.

I say ‘*effoy*’, taking a deep breath and thanking the lord for the comfort I have now. I say now ‘*effoy*’ comparing to my previous non-contraceptive use time where I was forced to bear children in close manner. During that time I had not enough time to care for them and hardly get time to rest. Now through contraceptive use I got relief from that for the last four years and living in ‘*effoyta*’, peace and rest. Our lives before contraceptive use were full of burdens with young children and looking for what to offer for them. It had made our lives stressful (both I and my husband), hectic and no ‘*effoyta*’ (III#17 site 05, Para.8)

My house is now upgraded from grass roofed to corrugated iron sheet cover. I live a decent life with dignity now and considered humanely both within my family and in my community. (FGD 06 dis #6)

However, lives this time is different from the previous one as we have got relative emancipation from the burden of unregulated and mistimed pregnancies and child births and able to properly handle our children. We are thankful to the Lord and the government so as we saw this improvement (our children are growing well and their body catches proper weight to their age) in our eyes. (FGD 07 Dis #6)

Physical movement related empowerment. Study participants in both in the FGDs and individual interviews explained their experiences before contraceptive use with regard to movement outside their houses as highly compromised. They said that to leave to move outside their houses, thinking to do so was unthinkable’ in the past. The main reason was unregulated,

too closely-spaced pregnancies and child births. Participants have repeatedly shared similar experiences in this regard. They lived either pregnant or lactating young babies. They knew no lives outside these phenomena. They mentioned that it was so common a happening for them that they got pregnant without any knowledge and stayed unaware until their belly would tell them.

Before, contraceptive it was known that my times were occupied either by being pregnant or caring for young children. These were some of the reasons earlier prohibited my participation in many social and economic affairs outside my home. You see..., when you are overburdened with routines including child care, household activities and outside home activities; you cannot think to move out from your home. Moving outside of your home in such situation not only harm your personal integrity but also end up in upsetting one's husband and results in conflict. (III #1 site 02, Para.3)

One can easily understand how stressful it would be to have many children in such close sequence. Women mentioned bitterly that they were puzzled as to whom to care for, how to prioritize, all of them were raising their hands to be hugged (xuxuluma⁹). The women said that, in such a dizzying domestic life, there were no means for them to freely move to the various personal, social, and community affairs outside their houses. They had no time to appreciate how the day gets in and became night. There were no opportunities for them to appreciate the changes in circumstances as we were overburdened with our domestic routines.

Earlier we were not comfortable to go out of our house as we were emaciated and shy to be seen before people. Now we feel free to work, move or go to different place such as social gathering. Before contraceptive use one of my neighbor ladies calling me “tutuluma, ‘xuxulumma¹⁰” as to indicate how close my births were. Her intimidation like ironic speech has awakened me to use the services” Korangoge FGD Dis # 5.

¹⁰ “tutuluma, ‘xuxulumma is a Sidamigna vernacular equivalent to putting in close sequence or order.

“By the time when I gave births to many children in close gaps, I was unable to go to market. I had many children in my house that surrounded me in the kitchen (FGD Woteragendo Dis #7)

Participants elaborated changes they experienced as contraceptive services users in terms of their increased movement outside the house. The use of contraception services, not being pregnant, and not having young babies at their homes have made it easier to the women to move outside their houses. They clearly expressed that they have got more time to go to market, meetings in the community, attending churches/mosque, and visit parents, etc.

Now, I am happy that there is no young child who will challenge me. As a result I am able to freely move to various social affairs and market. I do so as if I am a young girl. I feel full of energy inside. (FGD KF dis # 3)

Before contraceptive service use, I was like a prisoned person. I couldn't go where ever I want like my friends. But now I do whatever I plan and go where ever I want to go. In the past I had no time and opportunity even to visit my parents as I was totally occupied caring for my young children. Now the situation is different. I can stay for more time visiting my parents as my children are now big enough and can care for each other.

Thanks to the government which has brought this opportunity to our doors, our lives have improved. (FGD 08 Dis #6)

Contraceptive using women not only move out of their houses but also have mental stability and walk in a cool manner with their spirit at rest. They perform their duties outside the home in an unruffled and comfortable manner, unlike that of their previous state. In the past when they had young babies left at their houses, they rushed and left their duties half completed, did things in a hectic way, and half completed for fear of their young children left unattended in their absence.

Before this service, if we went to market, we returned half accomplishing our tasks as we thought that our young children were crying. Now we are thankful to our Lord. (FGD 03 Dis # 7)

I have no such difficulties to attend meetings at this time. When to put this in the era of contraceptive use and before, now I have better time to accomplish my domestic works and spare some times for significant social affairs. As of the time when I have started using contraceptive methods, we have mutual understanding with my husband whether to go somewhere outside my home or stay home. (III #1 site 02, Para.3)

Decision-making. Women's empowerment also takes into account women's decision making experiences at their household and community level. These include many things such as economics, participation in social affairs, movement outside their houses, expenses, children schooling, and health services access including contraceptive method use, etc. Specifics are explored below. Like other areas of this study, the issue of decision-making is discussed by the participants with due consideration of present contraceptive service use and former non-use.

As the study participants expressed their experiences towards decision making at their household levels, there are varying stages and results seem contingent upon their husbands. They express that there is overall improvement since they have started using contraceptive service.

For any decision in our house we decide together however, my husband has upper hand in passing decision remarks and following him I do add my view. I go to market, health institutions occasionally. I have no problem of getting permission to go for such issues from my husband. (III #3 site 02, Para. 4, line 1-3)

I go to market once in a week and nothing so far had happened. I plan to go to the market but inform my husband before I do so. I never do it without his knowledge. I take money from my husband to go to the market. I do nothing without his knowledge or informing him. Whatever thing I want to do, I have first inform him. These include: going to

market, expending in the market and involving in small scale local trading. (III #4, site 06, para.4 line 1-4)

Decision-making related to resource mobilization, utilization, and visiting health institutions are the areas where they have improved freedoms. In case of expenses, by the virtue of the time they now have, the women are able to generate income and freely expend for whatever issue they prioritize at their household level. Women have also mentioned their experiences in visiting health institutions and making decisions about contraceptive use and service as having greatly improved. They added to this that various women's unions have formed as an indirect result of the increased community participation and decision-making ability attributed to family planning. Women articulated that contraceptive service use is emancipatory and transformative for their lives.

There are some activities I perform without requiring his blessing [husband]. These include washing clothes, cleaning house, cooking food, and garden cultivation. I can sell some of the garden vegetables which belong to me but I cannot sell my husband's properties. (III#10 site 04, para 4 line 4-7)

"I do domestic activities such as food preparation, feeding my children, cleaning of house and other similar activities at house by my own." (III#13, site 04, para. 5)

However, study participants collectively expressed that their level of decision making regarding movement outside their houses to market and other far places is largely dependent on their husbands. Some of them said that the only thing they do is just inform their husbands they are going out for their affairs. For some others they need prior permission to go anywhere outside their houses. The study revealed varying levels of autonomy in decision making at the household level.

I go anywhere when I want to go with the prior notification to my husband. It is difficult for me to do so without his knowledge. We first discuss on the matter and then I go. I usually go to market twice a week (Wednesday and Saturday). When some urgent desires anticipate, I go as the demand comes to the nearby small market. With respect to

income/ resource mobilization either for my family affair or other social affairs, I never do alone. I present the issue to my husband and we jointly decide on how to expend.

When I bring the matter to my husband's attention, he either agrees or disagrees. I carry out when he permits. Otherwise, I never do it alone. (III#8, site 03, para.5)

Some study participants stated that they make many decisions collaboratively by discussing the issues together. However, husbands have the upper hands in passing final resolutions in cases such as school attendance and bigger resource mobilisations. Women mentioned that they have relative liberty to decide on most domestic activities such as cooking, fetching water, child care, housekeeping, etc.

With regard to physical movement outside home, I have no problem of doing so. We have smooth relation with my husband and good trust between each other. That was how I went to tertiary level education and completed it. In case of domestic decisions, we jointly make it. We discuss what to do for our children in their schooling and then buy all necessary inputs such as cloths, exercise books, pens, pencils etc.... We also decide household expenses together. He collects salary and come to home then we list expenses and execute it together.

We discuss all our family matter and decide consensually. One of us could initiates idea and then we thoroughly discuss and reach on decision. Almost all our decisions are in such condition. I may come up with one excellent idea that could greatly promote our family; I and my husband share it and finally act. However, the precedence for decision making is given to my husband. He is the one to take the major share about deciding where our children school should be, what expense is needed for them so on. (III#17 site 05, para 5)

Relational. Discussions and interviews were conducted with study participants both in the FGDs and individual interviews. The lived experiences of women in the era of contraceptive use

and their relations to their husbands, children and community members were addressed. Accordingly, women have elucidated their experiences related to marital relations, household level communications and their involvements in various community level affairs.

Before contraceptive service use, women's capacities to share their ideas to others within and outside their households were limited. Furthermore, they added that they were shy or not determined to talk or share their concerns to others in most instances. They had not enough time to process their feelings and share them with others. An excerpt from an interview from a woman clearly explains this as:

Before contraceptive use I was isolated from other people. Many people did not approach me as they undermined me for the status I had. My repeated and close pregnancies and births ruined my personal, economic and social status, thus they undermined me. You see..., pregnancy itself is a problem. It hampers your involvement from various household and social activities. You cannot actively be involved in many duties. (III # 13 site 04, para #6)

Before contraceptive use as we were busy with pregnancy and child care, we were unhappy to share beds with our husbands. As a result most nights were quarrelsome.

The man leaves house in the morning in desperate attitude as he was not properly treated in bed the previous night. He also refuses to eat lunch which was prepared with many challenges. (FGD 01 Dis #6)

They discussed in detail the challenges they had in communicating with their husbands. Some women have mentioned that they fear their husbands, even to raise matters that require or deserve discussion. They felt that their husbands might not favourably accept their ideas or they thought it may be considered disrespectful to them. For such and similar conditions they wanted to keep their feelings buried within themselves and their feelings remained subordinate to their husbands.

Besides these all challenges, my husband could not understand my problems. He wants to have more children. When I wanted to delay pregnancy, he always quarrels with me

saying that “let the day that I saw you be cursed”. We had disagreements for long times. Every day and night we were fighting. No peace at all. (FGD 01 Dis # 4)

Before contraceptive service availability and its use, we hated male. We had no good environment to think about what sexual feeling is. Our lives were tapped by many domestic work burden and demanding children care. As I said, we were not in position to care for ourselves and undermined our personhood. Therefore, we departed ourselves from our husbands. We lived in full of conflicting situation as our husbands urged to have sex but we denied their requests. (FGD 08 Dis #7)

On the other hand, their marital relations after contraceptive service use have shown tremendous progress. They expressed that this time they have established enduring relationships with their husbands. Most study participants shared they are now closely discussing their family affairs, service uses, children schooling, and marital relations.

Now I started using contraceptive method and able to avoid unwanted pregnancy and saved time for my husband. Now I made myself ready to properly treat my husband and fulfil his desire. I am okay to meet him all the time he needs, except forcing natural situation. (FGD 01 dis #8)

We do all things at our home collectively. We discuss issue of contraceptive as well. Both of us involve in income generating activities. There is no as such secret things like the old time. We talk to each other, share ideas about contraceptive use. Now we established good agreement; we feed from the same plate, we ask each other what to eat, which type of food to prepare. We are now safe and comfortable. (FGD 02 Dis #10)

With respect of live change since I have started using contraceptive service, I have many pleasant issues happened in my life as of the time I have been on contraceptive. With most impressing issue, my marital relation has greatly improved. My husband

disrespected me when I gave too frequent births and not in position to care for myself. As contraceptive service has allowed me avoid unplanned pregnancies and fairly use my time for family affairs and my personal life, now I am able to catch my husband's eyes. Our lives are now established in agreement and mutual respect and love. (III#12 site 04)

Women also have mentioned that their visibility in the community and various social affairs has improved. Now they are able to join social organizations such as women development armies, various economic enterprises like saving and credit associations, and women's unions. They have freedom to attend church and easily socialise with others. Some of them have received leadership positions in their community and mobilise other fellow women in various social, economic and political affairs.

Such spacing has created great chance for me to design my own income generating activities. I organized small group enterprise composed of eight men and sixteen women. We got credit from micro credit enterprise to initiate our actions. We are involved in income generating activities and generating our income. (FGD 05 Dis #6)

You see, we ,the women, were out of "form" or "action" before contraceptive use but now able to find ourselves as part of society and able to care for ourselves. We are able to clean our body, our clothes and improved our appearance before other group of society and improved our confidence to mix /socialise with others in the community. (FGD 08 dis # 3)

I serve as community mobilizer for women in my locality. I disseminate information about them in case when the *kebele* need them to attend meetings. I also organize sessions for health extension workers when they want to teach women in health extension packages. I also work as messenger for women federation in our *kebele*. These positions have given me to easily participate in most community affairs as a facilitator. (III #13 site 02, para 2. line 1-5)

They have also expressed the capacity to talk to others including their neighbours has improved. Most specifically, their ability to share information related to contraceptive service, its use and benefits to their fellow non-user neighbours has greatly improved. They adequately access services from the health extension workers by presenting their demand without any reservation.

I approach them telling my story. I try to reveal what benefits I got by using contraceptive method both for me and my children. I will tell them that if a woman bear children in close gap both the mother and her children are affected in health, nutrition and many other economic and social aspects. I will also add to them that contraceptive method use improved the love between a husband and a wife as they get better time to know each other and the woman can please her husband better than before. So, I will emphasis in all these matters and try to convince them. (III #10 site 04 last paragraph)

I strongly urge those women who are not currently using the services to soon come to the service and enjoy its benefits as we do. I know some women are still resistant to listen this information. However, I stand firm and detrimental to share my experience how it helped me to space unwanted pregnancy and involve in many social, economic and personal affairs. It is quite obvious that un-spaced pregnancies and births harm both mothers and children in many ways. Therefore, I say to them please use. (III #4 site 06, last para. last four lines)

Enabling conditions for contraceptive service provision and use (How do the health care providers seek to create an enabling environment for contraceptive service use?)

Under this study guided question, data were collected largely from key informants in a very flexible and open manner, with the aim of better understanding the issues of service delivery organization, processes and content related to service availability, accessibility, convenience, the broad directives or rationale for providing contraceptive services, trends and current status of contraceptive services, the pattern of service integration, linkage among the primary health care

units and the community organizations and anticipated challenges related to services sustainability and ensuring quality.

Experiences about the contraceptive services organization, its process and content in terms of availability, acceptability and convenience for clients. Contraceptive service organization, its content and process in terms of the service accessibility, availability and convenience as perceived by the service providers, managers, and users affect the service utilization. In the study area, informants have expressed their experiences in terms of the service availability and accessibility as service providers and managers. Notwithstanding some peculiarities, the informants posited that their experiences related to contraceptive service accessibility and availability in similar ways. Experiences of informants revealed that contraceptive service has passed various steps until reaching the current state. Informants mentioned that contraceptive services in Ethiopia in general, and in the study area in particular, has relative old age history of inception not less than fifty years. However, the service expansion and accessibility was limited only to the few urban centers at its early stage and took longer time until it became part of the primary health care and the health service package in formal manner. However, its expansion to most rural parts of the nation was very slow until the government declared a new innovative community based health service delivery approach, the health extension program.

This is further elaborated by one of the articulate informants about the service organization and its trends. A quote from his expression elaborates the idea:

With regard to contraceptive service in our country, it has been about fifty years since the service situated in place. However, its development was sluggish during the early and middle periods. At its early stage, it was started in one clinic under the FGAE. Since then, it has gradually developed. This time about 100 hospitals, more than 3000 health centers and about 16000 health posts are offering contraceptive services.

Another key informant further added his experience as both the practitioner and health service manager at district level by stating:

My experience in the health field both as a practitioner and a district health manager is as follows. Contraceptive utilization in the district has various faces. Before 20 years, the

residents in the district have never trusted on the capacity of the method in preventing pregnancy and hardly convinced to use it.

Similarly another well experienced informant in terms of contraceptive service expressed his view and experience in relation to contraceptive service trends by stating:

I have been working as a focal person for maternal and child health including reproductive health in this district since the time I was nurse. Since then up to now, until the time I upgraded to health officer, I have been serving health service in the aforementioned program. When I see the family planning program in general, formerly the services provided were limited both in quantity and quality. As of short fast, family planning service being offered to our community, its organization, patterns of service provision have improved both in quality and quantity. And the services are being given in integrated approach. This indicates that recently it can be said that the services provision is convenient to our society.

Since the establishment of the health extension program, contraceptive service accessibility and availability was not uniform across the continuum. But services patterns have gradually improved in its expansion and method mixes. At its early stage only the oral contraceptive pill was served at the health post level but this time it has expanded to include both short and long acting methods. One of our health extension workers was involved as a key informant, and shared her perception about the contraceptive service trends and its expansion in terms of improving access and availability in the following manner:

At initial stage we had only one short acting contraceptive method, the oral contraceptive pills. Sometimes later, the injectable (depo-provera) was added. After 2010 onward, Implanon and IUCD have been introduced. Implanon is given by us and IUCD by the partner organization in the health post or by referral at the health center.

In regard to contraceptive service accessibility and availability, in the past there were only limited contraceptive methods available. This was limited to the oral contraceptive pill at most service provision outlets such as health centers and health stations. Because of the efforts over the past few years, the service accessibility and availability with regard to the method mixes has improved. All the key informants at various levels ranging from the federal ministry level to the service users at community level unanimously expressed that the methods available have expanded to at least three at the health post level in direct service provision (pill, injection and Implanon). Other methods are also available within the short distance by referral at health center and nearby hospitals. Contraceptive methods at the health post are both the short acting (pill and injection) and the long acting method (Implanon). This was further articulated by one of the informants as expressed here:

Generally, the contraceptive service provision in the district is getting wider. Formerly, the service was limited to short acting methods such as pills, injectable and condom.

Now, the long acting services such as IUCD and Implanon have been introduced in the district.

However, despite the encouraging service expansion and improving method mixes some method shortage has been stated by some service providers. The contraceptive method mostly lacking is the injectable method (Depo-Provera). This is expressed by some key informant service providers. To more elaborate it the following quote is necessary.

With regard to supplies availability, we face shortage of some methods, specifically injectable method. What we used to do during this incidence was, we inform our clients about other available methods and to choose out of them. Thus, they switch from their former chosen method to another one due do method shortage.

The method shortage experience from the perspectives of service users is expressed in the following manner. The method formerly I used was injectable method and now I switched to oral contraceptive method. The reason for my switching was based on the

information I obtained as there was shortage of injectable method. They said that they have problems in obtaining it. (III #17 Para. 6 line 13-16)

Another informant added by saying:

“My worry is about method related shortage mainly that of Depo-Provera. I have great suspicion that this method might totally disappear.”

There seemed to be inconsistent expression about this issue among the key informants at various levels of service organization. Service providers at the grass-roots level (at the health post) expressed a serious shortage of Depo-Provera, which has resulted in method use discontinuation by some clients. It is also a shared worry of the women as the majority of women are using the injection method. On the other hand, higher-status health service managers claim that the shortage is an artificial one. In actual sense, there is no method related shortage for contraception including Depo-Provera. This is further elaborated by looking closely to the quote of one of the key informants:

As long as I know the process, the method shortage is not the actual one but it is due to planning and maldistribution problems. To ensure this, if you call the supplier, the PFSA (Pharmaceutical Fund and Supply Agency), they will say that Depo-Provera has over stocked in their store. The problem comes from lack of proper planning and good reporting system.

It is evident in one way or another that this is related to the overall process of contraceptive supply chain management. This would not only discourage service users but may ruin the hope they have built in their lives.

For any service to be effective and sustainable, proper resource management is one of the crucial inputs and processes to be in place. Similar to the expressed concerns about methods shortages; there is another concern regarding challenges related to contraceptive method availability and sustainability. A key informant from one of the study districts shared his experience and worries about this as:

No, we don't. We receive from the Zonal Health department or partner organizations.

The Zonal Health Department gets its share from the Regional Health Bureau and the

Regional health Bureau gets its share from the FMOH and other partners and distributes to the Zones and special districts accordingly. After we receive supplies from respective routes, we provide services for free. No payment is required for contraceptive service. This makes it uncertain for proper management and indication for supply chain management.

Along with the service accessibility and availability, the study elucidated how the service is offered to the users at the health service provision outlets with respect to quality. For instance, whether service providers have some reference materials on hand to guide their service provision and respond to the clients' questions as they are raised. From the field observation and discussions with the key informants, it is learned that the availability of reference materials such as manuals, guidelines, and leaflets is inconsistent among institutions. Some health posts and all health centers have hung some charts and manuals on the wall of service rooms and mentioned that they are making good use of them. Some of them mentioned that the available materials are adequate for their service provision. However, some of the service providers informed that the available manuals or their class notes during their initial training are not adequate to competently handle matters arising from the clients.

Managers at the higher levels of the regional and federal ministry argue that they have furnished the health services organization with adequate materials. In order to obtain detailed insight about the issue looking to the following quote from one of the key informants from the higher level authorities is crucial.

With regard to the guideline, we prepare the annual plan based on the aggregates of the regions demand and distribute based on their demand. We supply manuals together with other contraceptive supplies in the way I have mentioned earlier. Contraceptive and other supplies are distributed through the PFSA and our partner organization.

Experiences of the key informants about the broad premises of providing contraceptive service for the clients as one of the enabling situation for service provision. In the study, we are interested to learn about the broad premises on which contraceptive service is being offered to clients in the study area. Historically, contraceptive service has passed three broad premises as to why the service exists and is provided. Discussion with key informants revealed that contraceptive service is being given either to improve the health status of mothers and children, in order to harmonize the number of children with one's economic/ household arable land size and some other resources. The health and economic related premises were automatically heard from the informants. Almost all the informants did mention the health and economic rationales but the human rights rationale was less obvious for many key informants at the service provision outlets and lower level of health service management. Key informants ardently mentioned the health and economic rationale, as can be seen from the following quotes from the managerial and service provision levels:

One goal is improving the health status of mothers which further contributes to the health of the family, community and the country at large. Ethiopia as a developing nation has many socio-developmental challenges. For example, the nation has nearly eighty percent of its population in the rural part of the country where farm land size is depleting over time. This means that the rural land ratio to the population is significantly reduced and thus agricultural productivity. It is obvious that the district has no means to expand the land. Some of the challenges are related to unregulated fertility which could have been normalized through availing contraceptive services to our clients.

We have huge population now. If you see here in our local *kebele* the number of people and what they have to eat is not in balance. If they have limited number of children, they can properly feed their children. So, one of the rational is to harmonize this problem.

When I say this, providing contraceptive service, the service users can bring about regulated child birth in relation to their economic status.

The health and economic rationale/benefits were well expressed by the service user women. The study has revealed the livelihood changes of most service user participants as being positive in comparison to pre-contraceptive use. An excerpt from a focus group discussion explains:

From the time I have started using contraceptive service, I started to space pregnancy for at least five years. I got adequate time to properly handle my children, breast feed adequately and grow well. My health status is improved and gained strength. I reached to state of deciding when and how to get pregnant in connection to my health and economic status. (FGD BF Dis #1 line 10-13).

Health managers at higher levels have beautifully expressed the human rights rationale for providing contraceptive service. Let's learn from the eloquent statement of one of the higher level informants:

The main reason contraceptive service is being given to citizens in our Country is based on the national constitution as health is the right of people. The constitution enshrines that every woman has the right to decide on the number and timing of children she wants to have. It is clear that reproductive rights are basic human rights. Therefore, citizens have the right to get proper knowledge and services related to reproductive health including contraceptive service. The other one is related to the desire of couple to limit or space the number of children they want.

Discussion with key informants clearly reveals that the economic/demographic and health rationale is being given major emphasis. The informants explained this by stating that Ethiopia as a developing country strongly needs to regulate population growth in relation to its socio-economic status. The study area is characterized by this perspective, with the aforementioned rationales being top most in the agenda. This idea is expounded by one key informant and top health manager at the regional level:

By the way the demographic rationale of contraceptive service for a nation like ours is mandatory and no negotiation is needed on this matter. This is not only from the global

or national perspectives but if you go to the family level, they tell you about it. You can easily observe a family postponing pregnancy for long time even without have one child. When we ask them why, they tell you the challenges they anticipate in up bringing them related to demographic and economic problems.

In order to demonstrate the progress in respect to socio-economic dimensions, the country must harmonize the population growth with the economic growth. This harmonization can be materialized through proper organization and expansion of family planning services in country where Boricha district is one of the critical areas to implement the program. When this broad rationale/goal is translated to the context of this district, the primary rationale is the economic and health rationale. (KII #1. Para 4. Line 3-8)

However, there is a disconnect in the comprehensive understanding about contraceptive service provision from the human rights rationale, and this affects the provision of contraceptive services from the premises of the ICPD agreed plan of action and proliferation of the human rights based approach. I argue that if health managers at the district level and service providers at the health center and health post levels do not speak of human rights issues whatsoever, how can the system ensure a right and timely approach? It is clear that the health and economic rationale is crucial for the study area but in order to sustain the benefits for women, it is essential to address the issue from a standpoint that incorporates human rights – to not do so is not an option. The study process revealed most women did not understand their challenges are being related to the larger issue of human rights. Yet all women expressed appreciation that the government had made services available at their vicinities. This might be seen from different angles. On one side, the lack of such service in the past time and the challenges they faced as a result forced them to appreciate the current positive outcomes related to the service availability. From the other angle, women might have not considered the obligation of the government to offer such service for its citizens. Moreover, together with other factors such as their low educational level and economic status, they had no exposure about their rights, especially with

regards to reproduction. For instance, in this study women expressed that they have little autonomy about saying no for the request of their husbands in any circumstance whether they like it or not.

Trends and patterns of contraceptive service provision in connection to the HEP. If there has been any difference in the progress or service expansion in the time of HEP and what has been contributed for the achievement?

A. *Health managers and service provider's perspectives.* In Ethiopia in general as well as in the study area, contraceptive service provision began over fifty years ago, but its progress in reaching all segments of society was very slow. At its earliest time, the service was being given by voluntary non-governmental organizations such as the Family Guidance Association of Ethiopia, and others. Very gradually the service was integrated into the health service system. However, its progress was slow until 2005. Contraceptive service expansion and method mixes have sharply increased since 2005 in the study area. Whether the establishment and launching of the community based health extension program has been one of the driving factors for this remarkable expansion, was a study question the key informants and discussants were asked. Almost all the study participants in three data collection areas: the FGD, key informants and individual in-depth interviewee, boldly expressed that the health extension program has contributed to the current state of contraceptive affairs both in expansion and in making a variety of methods available.

Study participants mentioned that the health extension program has brought contraceptive service closer to where residents reside and work. By doing so, it has improved the ease of unconditional access the service. In the former strict institutional health service delivery system, women were forced to walk long distances and subjected to long waits as there were many people to be served. Moreover, they commonly faced either language barriers or gender barriers in order to comfortably explain their desire.

The health extension program, unlike the previous approach, extended the services to the household level through home visits and other community based distribution options using community based organizations such as women development armies. The health extension workers are female and enrolled from the same *kebele* where they offer service. Therefore, women feel at home when they visit the health post to access contraceptive service and when the female HEW visits their home; they speak of their needs without hesitation. They share similar

culture and speak the same language and being female created good opportunities for women to ask what ever questions they wanted. Study participants substantiate these conclusions:

The health extension program has extended the service to community and household level so that improved access and utilization. Another important issue to be considered with the health extension program is that all the health extension workers are female and selected mostly from the same *kebele*. This offered exceptional opportunity to women by reducing the gender mismatch between the service providers and service users. On top of the above, the health extension program eases the time needed of service as the service has come close to the clients, reduced travel and waiting time. This also improved both availability and convenience to clients.

The reason for the rapid increment in contraceptive prevalence and service coverage in the district as of the last seven years is clearly attributed to the health extension program. The health extension workers provide this service not only at health post but also house to house visitation. The health extension program reduced the former health services distance to two to three kilometers walk and stretched it to household level.

The study has revealed that alongside with the establishment of the health extension program, strengthening the service link within the primary health care units and the community using various approaches has greatly contributed to the current state of contraceptive use. More specifically, community mobilization using women development armies, a one- to- five network¹¹ through model household are the notable ones.

The health extension workers receive continuous supportive supervision from the health center designated supervisor. This does not only improve the confidence of the health extension workers on dealing with some contraceptive service beyond their scope, but also strengthens the service referral linkage between the health post and health center by creating direct communication through the supervisor. Key informants, focus group discussants, and individual

¹¹ A one-to-five network means a model woman in one of the five neighboring households; act as a team leader (due to her outstanding performance on the health extension program) for all development related affairs in that team.

interviewees have clearly explained the service organization, its linkages, and collaborative undertakings at community level. The health extension workers work closely with the women development armies and a one-to-five community networks in order to ensure the expansion of contraceptive service within their catchment area. Such interlinks/ collaboration among stakeholders not only improves service access but also a clear indication for women empowerment as the service providers, advocates, and community leaders being women for contraceptive service. These are further substantiated by directly citing what the study participants mentioned:

One of the key informants at district management level explained about the issue as:

Health professionals from health centers assigned to support and supervise health posts.

The district health office in its part work closely with both the health center and health post. The linkage is not only limited to family planning program but also is extended to other health services (health extension packages).

In similar way another well experienced health extension worker has given her experience in this regard by clearly indicating that:

The relationship of health extension workers to the family, community and administrative hierarchy from the very beginning was strong and collaborative. Our relation is very strong as like that of cohesive family members. Our home to home visiting program helped us to know the inside of our community very closely. We mostly contact a woman at household. We visit family's house in person and observe household situations including housing condition. We have established remarkable relationship and mutual trust. Another channel we work together with family and community is women development army organized in our *kebele*. In addition to that we have also a one-to-five network system. We also use other community organizations such as '*edir*' and '*kuteba mehiber*'. We work collaboratively with all these organizations, networks and systems.

Generally, we have established strong working relationship starting from a woman to the community level.

The role of current contraceptive service user women in the expansion of service to their non-user neighbours should not be neglected. On top of their service use, women who currently use contraceptive service also transmit information to their neighbour non-user women and significantly act as a source for contraceptive information.

The following quotations of some of the discussants give more insight about the issue:

It is my routine duty to tell them the benefits of contraceptive methods. I tell them if they use contraceptive method, they can plan the number and time when and how many children to have. One of my neighbour women, despite my telling, she continued to bear children looking for the male. After having many children, now she has started to use it. I keep on informing them about the benefits of contraceptive services. I say to them that the service will enable you to space your pregnancies and child births so that you will get enough time to spare for other personal and family affairs. I also have disclosed that contraceptive method will enable you to be clean and tidy. You will get time to feed well and maintain your health properly. Some of them have just started using the service.

B. *Service user women's perspectives.* Experiences of service user women towards contraceptive service availability and accessibility in the era of health extension program are congruent with the health service manager and service providers' articulations. Women have explicated their experience in contraceptive use since the establishment of the health extension program in their *kebeles* has not only eased their physical discomfort in walking long distances and waiting for longer times, but also fostered closeness in their service use with the service providers. The health extension workers are women themselves and are also share the same language and culture.

Women justified in amazing ways that, unlike the previous high level health institutions, now they comfortably express their feelings and get service and advice in an easy and understandable manner. They never fear or feel ashamed to tell their feelings as the health

extension workers are from the same localities. When the health extension workers visit clients' houses, women easily talk to them and even invite them to have coffee or something to eat. The reason is that, they feel at home and well acquainted to each other. This was not the case before the health extension program.

One of the focus group discussants expressed her feeling about the service access currently by saying:

We access contraceptive services in our *kebele* easily. We receive the services on our respective appointment dates without any worries and go back to our house to do our works. In the grace of our Lord and due to the commitment of the government, now we are freed from challenges related to mistimed and unplanned pregnancies and their related burdens.

Another woman in the focus group discussion who has used contraceptive service from various sources elaborated the service access difference and the convenience now and then for her as follow:

I paid 270 ETB for contraceptive service (surgical implant) at Yirgalem hospital before the access to contraceptive service improved. I also waited for five days to get service besides paying the money stated above. Now the situation is different. Service accessibility was greatly improved. As the former discussants mentioned, we got service here at our *kebele* by our children. This is really big shift. We told all our feelings without keeping it secret to the health extension workers. We don't have problems of long waiting hours for services, no need to go on daily base to queue up for services, no one say us bring your card from card room. We receive services at one stop shot. (FGD 02Dis # 10)

In similar manner another woman in one of the focus group discussions has vented her experience by exclaiming that:

More specifically we have got better health services both for our children and ourselves as the time of the establishment of the health post in our *kebele*. We were largely troubled with our children born before the establishment of this health post moving here and there seeking health services. We also were forced them to take to medically unproven services and exposed them to unsanitary/unhygienic services. Some of our children have lost their lives and others remained disabled. Now we are grateful to both our God and our government for them to avail the health post in our *kebele*. We got relief and our children are growing well and healthy.

A 25 year-old lady used contraceptive service for five years from FGD site 06 explained her lived experience as how she has been benefited from the service as:

Things are different today. Instead of going far to look for the service now I am accessing contraceptive service here in my *kebele* with a short minimum walk. Before the health extension program if one needed to use contraceptive service has forced to walk long distance and time and financial barriers were another bottle necks hampered from service use. Now thanks to our God and the government, we receive health information in daily basis. The health extension workers advise us on how to keep our personal hygiene, different types of contraceptive methods available in the health posts and elsewhere, inform the benefits of contraceptive use about spacing pregnancies there by improving the health status of both mothers and children. (FGD 06 Dis #1 P 39, para. 1, line 3-10)

Moreover, women expressed that the health extension workers are the first sources to bring contraceptive information and services to them. The majority of women started using contraceptive service after the health extension program. They have also mentioned that health extension program has improved their knowledge and skills toward other health issues in an integrated manner. Women have mentioned that through their home visiting program, the HEW teach them about other packages of the HEP.

This is further evidenced by the excerpts from the participants as:

I was not aware of contraceptive use and related benefits before the health extension program. Health services were not accessible in our localities before this program and we were ignorant about health services such as contraceptive use and vaccination. When the health extension program has been established in our *kebele*, the worker started to inform us about various health extension packages including contraceptive use and related benefits. They showed us the difference between unplanned and planned fertility and mechanisms how to control fertility. (III #18, p. 36, Para. 3. Line 1-7)

Women also have mentioned the contribution of the health extension program towards children's health conditions. They have said that the establishment of health posts in their vicinities improved the health status of their children. Using the advice given by the HEW and using the services, child sickness have significantly reduced.

For example, a woman among the individual in-depth interviewees has elaborated this idea in the following manner:

Since the establishment of the health post here in our *kebele*, our children have no problems. Even I do not remember whether they had big headaches. I have gained better knowledge how to handle my children since the time of this service. The health post has helped us in providing bed nets which prevent mosquito bites. We also have been educated to improve our personal hygiene and sanitation. These efforts have greatly decreased the likelihood of our children incidents in illness. (III # 19, P. 42. Para 4. Line 2-7)

Anticipated challenges related to contraceptive service sustainability and strengthening. In the study, besides enabling conditions to current contraceptive service provision, I looked into the challenging aspects on how to sustain the service and further strengthen it both quality and quantity. Although Ethiopia is making immense strides to expand contraceptive service to its population, there are some challenges that need attention. The study participants stated their concerns about project challenges included not being informed of the budgetary aspects, on account of being low within the project's administrative hierarchy. Lack of a defined budget for contraceptive service both at the district and health institution levels and being largely dependent on donors, is one of the challenges they anticipate most. They mentioned that except for the contraceptive supplies, there is no designated budget items for other related executive actions.

They added that this lack has created gaps in training and supervision. If the district health office or the health institution provides an adequate budget for such activities, service quality and sustainable use can be ensured. Aside from budgetary concerns, an administrative bureaucratic bottle neck at the district finance office level is another head-ache for smooth undertakings. Due to the lengthy decision-making processes and lack of willingness to mobilize the allotted budget, it has not been uncommon to pass the prime time for planned activities interventions. Thus, the situation has been one of the more de-motivating factors for both the service providers and clients.

A quote from one of the key informants can elaborate the above statements as:

The outstanding challenge in respect to the sustainability of contraceptive service is resource problems. Now, information dissemination has reached almost the blanket coverage, and new service users are increasing. Occasionally, we face shortage of contraceptive supplies and related inputs. Some activities are very urging but to accomplish them we need enough resources including fuel for supervision. Some problems are also related to the bureaucratic bottle necks. When we go to mobilize the allotted budget from the district finance office, they are not willing to facilitate the

process. Sometimes we experience to get decision after the critical time passes. (KII #3. P. 17, para. 2, line 3-8)

In a similar way, another informant also added:

There is inadequate recognition from the district administration level. They consider that contraceptive services are less important and put in remote priority. As a result, no adequate budget is allocated to this service. They also want to consider as the matter is the responsibility of the health sector alone. (KII # 4, P. 22, para. 3, line 3-7)

In connection to the budget source and fragility of the means to sustain it, one informant mentioned his experiences as:

With the regards to budget, there is no defined budget for contraceptive service at district level. The service is mostly dependent on non-governmental organizations and donors. To maintain and improve the quality of contraceptive services, the district is desirous to offer continuous in-service training in terms of refresher or initial training. However, the district doesn't have designated budget for this purpose. As a result, the district is totally dependent on donors. (KII # 2 P. 9 para 3 line 3-8)

Some underlying tradition and culture that still hinder use of contraceptive services include inadequate male participation in contraceptive service use, lack of motivation from the side of health service providers, inconsistency in supply management, burn out, clients' dissatisfaction with the long acting methods and disparity in service use and provision from place to place and across various age categories.

One of the senior health managers at the federal level stated his anticipated challenge related to the contraceptive service at the national and regional level as:

One of the challenges we observe in relation to contraceptive service delivery is that the success is not uniform across the country. There are variations from region to region and from one area to another. There is huge unmet need for family planning in the pastoral

regions such as Somalia and Oromia. We have also huge unmet need around youths.

Generally our challenges are disparity based on regions and socio economic aspects in general.

Also a senior regional health manager explained the challenges they face in the region including lack of service up take for long acting and permanent methods, low male involvement and problems related to the new HMIS failure to capture all service users for contraception.

One of the challenges is lack of/inadequate male involvement in reproductive health in general and contraceptive services in particular. The other one is problems related to the HMIS where the current one is not capable of capturing all women using contraceptive users in comprehensive way. When I talk about the data handling system, we talked about the public health institutions alone. But significant numbers of women are receiving from private health institutions where we have little connection with regard to recoding and reporting.

Service providers at the health posts and health centers also share their worry and anticipated challenges related to the service. A health extension worker in one of the health posts elaborated her anticipated challenge for the sustainable and progress service provision:

Yes we have. Just before short past, we have been facing shortage of Depo-Provera in our health post. As I have already mentioned above, the majority of our clients prefer Depo-Provera. But, we have shortage of this method. When women visit us in look for Depo-Provera and when we are in short fall, we inform them if they could take Implanon. This time, clients not easily get convinced. We are a bit sandwiched in between. Another challenge is that the chronic inconvenience in the working environment, lack of clear

professional career and subject to long working hours. These all may end up in burnout and out migration looking for other job. They also compromise with efficiency.

Another area of concern with regard to the anticipated challenge is the lack of a concrete and shared understanding about the process of Implanon insertion and inability to remove it by the same by the health extension workers. As part of the task shift to enhance long acting contraceptive access, the government has enabled the health extension workers to insert Implanon. But, they are not trained to remove it. This has created huge dissatisfaction both by the health extension workers and the women. Some women needed Implanon removal before its due date and approached the health extension workers to remove it. However, the health extension workers are not trained to remove Implanon. This circumstance has created a lack of confidence in the women and the health extension workers and remained one of the most important challenges for the improved up take of Implanon by new clients.

In connection to the above idea one of the key informants gave her experience as follows:

For example, when we refer a woman for Implanon removal to the nearby health institution, they feel discomforted and challenge us by saying why you do not remove what you have inserted. They are not happy to go far place for such services. If health extension workers are allowed to remove Implanon, this will surely minimize women's dissatisfactions. (KI # 9, P. 46, para. 2, line 5-9)

Conclusion

Results of the study are summarized under the study questions and convenience for presentation in the text. Accordingly, the quantitative study findings were first presented using tables and graphs with necessary descriptions. The qualitative study findings presented strictly following the study questions order. Results from three sources of data (key informants, FGDs and individual interviews) are summarised together in most cases. In order to reveal the power of the finding, direct quotations from the study participants are included in the result. Such result presentation has been helpful in guiding discussion of the result where discussion followed similar patterns and explicated the detailed views of the researcher in relation to supportive literature to the participants' experiences.

CHAPTER 5-DISCUSSION

Brief Introduction

This chapter introduces some summary points and some further points of discussion. It includes three major sections: 1) a methodological discussion revealing several epistemological and practical challenges related to language translation in the process of study and the mechanisms used to deal with the challenges encountered; 2) summary discussions of the study findings organized largely by the study questions and objectives; and 3) a re-framing in practical terms of the perceptions of the health managers, service providers and service users, in order to consider the significance of the study for service provision and the health extension program. The chapter ends by considering related challenges anticipated in the future.

Methodological and Epistemological Challenges in the Process of Translation

The study generated qualitative data from three sources: the key informants, the focus group discussants, and the individual interviewees. The key informants and some individual interviewees spoke the national language with me, and in those interviews, no language-related barriers were encountered. However, the majority of the rural women who participated in the study did not speak the national language of Ethiopia (Amharic) and I, the researcher, do not speak their local language of Sidamigna. Therefore, the study process required research assistants (interpreters or translators) who bridged both the language gap and related cultural barriers (Polkinghorne, 2007).

Use of interpreters or translators in qualitative studies is laden with challenges in the study process from data generation to study outcome and knowledge production (Temple & Young, 2004). These challenges can be seen in both epistemological and methodological terms (Squires, 2009). Epistemological challenges among researchers can arise from the differences in world views regarding knowledge production, and the positions and patterns of relationships among the study participants, research assistants and the researchers (Squires, 2009; Temple & Young, 2004).

There is a distinct difference in worldviews about the research process between the positivist/naturalist view and that of the human sciences/constructivist/interpretive/feminist/post-modernist view. The positivist stances explicate that in the process of knowledge creation, the researchers, translators and interpreters' roles should remain neutral; that only the data should speak of the reality. This view is generally called reductionist as it reduces the human attributes

(values, beliefs norms, and experiences) to mere numbers and figures. The human sciences or constructivist view of knowledge creation sees knowledge production as a joint effort in which the values, beliefs, experiences and context of the participants play a greater role in the process (DiBartolo, 1998; McEwen, 2011; Monti & Tingen, 1999). The roles of the researcher, interpreter, and translator are beyond that of mere instruments, but are part and parcel of the process of knowledge creation (Larkine, Dierckx, deCasterle & Schotsmans, 2007; Squires, 2009). Furthermore, the constructivist/human sciences view recognizes different forms of knowledge production as valid.

Hence, this study was conducted under the premise of the human sciences worldview that recognizes the roles of the researcher and interpreter/translator as part of the research process, creating knowledge together with the study participants (Temple, 2002). From the epistemological point of view, the study participants - the primary source of information - are greatly valued. Their experiences, values, beliefs and norms broadly influence the process of knowledge creation. They are the knowers; more than mere sources of information which others analyze and interpret (Temple & Young, 2004).

Language plays a crucial role in sharing in-depth values, beliefs, experiences and norms (Kapborg & Berterö, 2002). Unlike the traditional mainstream naturalist approach, the human sciences view treats language as a powerful instrument to explicate participants' experiences through their words, metaphors, rhetoric, body languages, and emotional expressions (Temple, 2002). The likelihood of exploring rich descriptions of the participants' life world is compromised when the researcher does not speak the same language and share a similar cultural background (van Nes, Abma, Jonsson, & Deeg, 2010). The reason is that meanings of words and phrases vary contextually from culture to culture and even direct word to word translation is not usually adequate in addressing such issues (Edwards, 1998; Squires, 2009).

Participants in this study spoke Sidamigna, part of the kushitic language family. Ethiopia has more than eighty languages and about two hundred dialects that can be broadly categorized into four linguistic families: Sementic, Kushtic, Nilo-Saharan and Omotic (Gordon, 2005), however, detailed description of Ethiopian linguistic history and nature is beyond the scope of this study.

In order to minimize the language related gaps and derive rich experiences from the study participants, interpreters/ translators were used (Squires, 2009; Temple, 2002). In terms of

epistemological challenges, interpreter/translators have helped to overcome these in several ways. First, the research assistants developed a view that the research being undertaken was a joint effort in which they had a stake; the relationship between the research assistants and I was not hierarchical. Secondly, once the research assistants established a firm relationship with me, this bond acted as a strong starting point from which to bridge the gap between the researcher and the participants. The research assistants bridged this gap by revealing the whole process of the study clearly and understandably to the participants with whom they shared a similar cultural and linguistic background.

The methodological and practical challenges were of similar importance and handled accordingly. The need for translation/interpretation in the study's research process was recognized, and technical, administrative, and financial solutions were sought (Wallin & Ahlstrom, 2006). Ethical clearances were obtained from both universities, indicating the scientific soundness of the need for research assistants in the form of interpreters/translators. Research assistant recruitment and selection was carried out (see the methodology section for details). The selection of interpreters/translators was given careful attention with regard to competence, experiences, gender, and cultural background (Adamson & Donovan, 2002; Berman & Tyyska, 2011). This process was accomplished with the support of relevant offices and friends. All the research assistants were female (the same gender as most of the study participants) which avoided a gender gap. The research assistants were ethnically Sidama, spoke fluent Sidamigna (the participants' language), were health professionals with good professional experiences in reproductive health (relevant to the study topic), and had been previously exposed to related research undertakings (Edwards, 1998; Squires, 2009).

Following selection, training on the research purpose and process was carried out over two days and pretesting was done before the actual data collection. This helped to establish a shared understanding of the research process between the researcher and the research assistants (Tyyska, 2011). It further helped to equalize research team relations and empowered the research assistants by making them feel an important part of the study (Manning & Denman, 2003; Savan, Kolenda, & Mildeberger, 2008). On top of training, every day after the fieldwork we discussed the daily accomplishments, lessons learnt, and challenges experienced. We offered practical solutions if problems arose, which contributed to strengthening the working relationship and building trust.

The interpreters/translators played important roles in interpreting the focus group discussions and individual in-depth interviews (Temple & Young, 2004). They also transcribed the audiotaped discussions and interviews and translated them to Amharic. I then translated the Amharic transcripts to English. A language expert then translated the English version back to Amharic and Sidamigna to check for consistency in meaning. A summary of the results was then discussed with the study participants in Sidamigna to learn more about the consistency of the findings with the original discussions (Polkinghorne, 2005).

There were practical challenges observed in relation to the above process. The whole process was resource intensive; timing was crucial in order to follow up with participants for another thirty-to-sixty minutes. One of my research assistants joined an MPH program in the middle of the research, which made it difficult for her to produce the transcripts on time. Another issue was that of moving steadily line-by-line and page-by-page through the transcriptions and translations, which took a lot of time. In a few cases some additional points were raised during the second round of interviews, indicating the necessity of such methodical review. Above all, the second round of meetings with the study participants enhanced the credibility of the study process, as the participants were happy to hear of their contributions (which is not the case in many other studies) (Doyle, 2007; Caroline, Fiona & Sally, 2010).

Why It Matters: The Centrality of Women's Control over Their Fertility

The guiding approach or central tenets of this study emanate from feminist perspectives, and in particular, illustrates how central controlling fertility is to changing women's position/roles in a society (Irwin, et al., 2006; Yuill, 2012). Gaining control over one's own body and the right to make decisions regarding sexuality and reproduction cannot be underestimated and requires that the systems providing contraceptive services be organized around such rights. Reproductive rights and women's rights are inalienable human rights that have to be fulfilled without any subjugation (Cottingham, Germain, & Hunt, 2012; Shalev, 2000). Using feminist perspectives helps to interpret the contexts and ways in which these rights can be enacted for the improvement of women's lives in developing nations like Ethiopia (Long & Dunphy, 2012; Ramazanoglu & Holland, 2002).

From a feminist viewpoint, I argue that the prevailing patriarchal social structure in Ethiopia, in connection to socio-cultural and economic dimensions, has greatly affected the overall status of women including their health and capacity to fully develop as human beings

(Crump, Logan, & McIlory, 2007; Lahey, 2010; World Economic Forum, 2014). In this rural part of Sidama, this is evident in their lower status compared to male counterparts, except for a few sporadic cases in which some prominent women leaders tried to balance the situation. Notable among these women is Furra, an iconic feminist in Sidama who tried to emancipate women from various social inequalities (Hameso, 1997). She tried to improve the gender gap or power imbalance between men and women. One of the doctrines she taught her fellow women was “do not accept everything men request; challenge them”, a sentiment rightly expressed by the study participants (Hameso, 1997). At some level and in some way, the women of the study have done that – beginning by taking control over their fertility.

What might be termed the biological privilege of reproduction endowed to women has not been demonstratively beneficial for those in the least developed parts of the world. On the contrary, women of these regions face disproportional challenges to their wellbeing. Interestingly, a majority of the problems are preventable with the available remedies at hand, when there is enough commitment and when women are placed at the center of a nation’s affairs. In Ethiopia, both societal and governmental structures were not conducive to women’s empowerment for much of its history. Rather, social structures engaged in overt and covert exploitation of women, until rudimentary attempts to change matters came into existence in 1993 (Gita, 2000; Raphael & Bryant, 2006; TGE, 1993).

In this section, the discussion of the study’s specific findings is conducted with the above considerations. What follows is a summary of the perceived benefits of contraceptive use towards health and empowerment, and a consideration of the kind of environment conducive to women’s contraceptive use in Sidama. Empowerment is considered in terms of women’s agency (economic and educational), autonomy (decisional, psychological and self-esteem), mobility and relational aspects. Categories are not strict, however, and overlaps are common.

Why Contraception Matters to Health. The perceptions of women regarding health-related experiences before contraceptive use, enabled me to reflect on my professional observations and challenges concerning maternal and child health. During my years of working in rural areas, I experienced many prolonged and obstructed labours at the health center level with limited professional preparedness. When I referred women to the next possible hospitals, situated more than 100 kilometers away with no means of transportation, women stayed home waiting for natural outcomes - often death.

In the study, women's experiences are examined before and after contraceptive use, with the results detailing differences in their health experienced after using contraception. The experiences revealed that women's health status before contraceptive use was generally poor. Women experienced very weak and dissatisfying livelihoods with subsequent poor health, illness, undernourishment, and unhygienic and disparate circumstances that further adversely affected their wellbeing. Lack of access to modern contraceptive services adds to the prevailing conservative culture and patriarchal attitudes that affect women's health in many ways. The women reported high child mortalities and morbidities, and unregulated fertility through closely spaced pregnancies and childbirths. Many children died before reaching their first birthday due to lack of proper care, and those who survived suffered from illness and under-nutrition. These results echo those of many other studies (CSA2001, 2006; 2011).

In the study, the stories shared by the women when describing their lives following contraceptive use were very different than those preceding contraceptive use. Women's experiences following contraceptive use showed that first and foremost, they were able to control reproduction, and by extension their bodies, and thus exercise their human rights. Women identified contraceptive service as a miraculous gift from their Lord/God and the government. Contraceptive use enabled them to enact family planning and postpone unwanted/unplanned pregnancies. Their ability to plan pregnancies helped to improve their health status in many ways. Overall, frequent illness and hectic livelihoods have been gradually transformed into healthy and peaceful lives. "I have got peace and stability" is in fact, a profound statement.

Contraceptive use has also contributed to the improvement of children's health status. When women space pregnancies they are able to provide proper care for their older children. Older children have enough time to feed on breast milk. When they reach the age for complementary feeding, a woman has more time and capacity to feed her child, unlike previous

pre-contraception scenarios. Children also receive better health services. Contraceptive use created another beneficial opportunity for women to learn about aspects of child health such as vaccination and nutrition. As a result, children born to women using contraceptives receive vaccinations and grow well. Additionally, women are able to take their children to health institutions more easily, as they have increased time and awareness.

The women's experiences indicated that their lives were transformed following the use of contraception. They considered themselves most fortunate, as they were able to escape that dark time in which they lost many of their sisters and mothers prematurely due to complications during pregnancy and childbirth. High infant and child mortalities are not a matter of simple numbers for those families, and more importantly those mothers, who face it; it involves a loss of hope, feelings of great sorrow and of quarrelling with God (Hardee et al., 2004; Karacam, Onel, & Gercek, 2011). Women, therefore, see themselves as most fortunate to experience this transformation in their lives at their ages.

Contraceptive use and women's empowerment. A second important dimension considered in this study is women's empowerment. Contraceptive use is fundamentally empowering women in four ways: 1) economic empowerment and agency 2) personal autonomy 3) mobility 4) effects on relationship to family members and community.

In general, women's experiences in this study revealed that contraceptive use is emancipatory and transformative to their lives. When it is said to be emancipatory, contraceptive service played an important role by enabling women to avoid unwanted or mistimed pregnancies and keep them free to be involved in many activities beyond the reproductive horizon. Studies in Bangladesh, the US and West Africa also support the conclusion that contraceptive use has improved women's ability to be involved in productive work and other socio-cultural aspects by averting unwanted pregnancies (Bailey, 2006; Conde-Agudelo et al., 2007).

Economic empowerment and agency. Women's experiences clearly indicated huge livelihood challenges in the study area. Women expressed worries that their land size was diminishing and its productivity decreasing, as they were unable to allow the land to rest. Land is the principal source of a rural household's livelihood; however, the resources generated by household-owned land has not been sufficient to support large and ever-increasing family demands. Shiferaw (2006) argues along this line, stating that when there is uncontrolled fertility,

the population growth is outpaces the capacity of natural resources, resulting in a poverty trap that further aggravates rural livelihoods.

Contraceptive service appeared to be one of the mitigating factors in harmonizing the ever-growing demands on the limited resources of the household (Bailey, Heishbein & Miller, 2012 Canning & Schultz, 2012). Unplanned pregnancies and childbirths stress household finances. Contraceptive use functions to harmonize the family income with family size. Preventing unwanted pregnancies means creating increased opportunities for the household to generate more income. A woman, on top of her domestic responsibilities, is able to engage in economic activities where she can generate income.

Women have more time to engage in income generating activities and thus boost their families' resources. Newly obtained free time has enabled women to think carefully about which income generating activity would best match their situation and provide the best return. They are able to think and plan; setting proper priorities to become involved in income generating activities (hence the economic activities enhance decision-making capacity).

Women's experiences further revealed that when their chances of being involved in income generation increases, their capacity to properly manage resources also improves. Following the implementation of contraception services, women in the study area became more conscious of the use of resources at the household level. Women took responsibility to advise their older children regarding how to use the few available resources in organized and economical ways to fulfill the needs of household members. Women also learned that they have obtained opportunities to minimize waste and preserve resources for unexpected needs. This is another positive experience that could further improve community and national development through saving and investment.

Agency: Education. Education is one of the most influential means for women's agency. It helps to mitigate household and individual-level poverty and livelihood challenges. It is also the best strategy to ensure one's maximum potential through human capital development. However, women in the rural part of Ethiopia have not been able to fully enjoy the benefits of education. As a result, they live in poor status. The intricate livelihood situation with its resultant poverty showed trans-generational patterns. Women's lack of education is a result of the underlying male-dominant culture, a lack of access to education in previous decades, domestic workloads, harmful traditional practices, parental poverty and peer pressures: aspects

that were all present in the lives of women in the study. People in the study area discouraged girl's education by saying that "the best education for a girl is to master domestic work through helping her mother at home." Another excruciating condition was early marriage, which often ruined girls' educational chances. A particularly humiliating local saying in the study area, which works against girls' education, was "let the girl and a dead body leave the house early". This was in line with the culturally embedded thoughts in the area that if one invests in a girl it is only benefits others and not the family, as a girl ends up married anyway, and this requires resources to be transferred from her parent's house to her husband's house.

Girl's education is also hampered by household work. A mother, heavily burdened with domestic work, often does not wish to send her daughter to school; rather she prefers that her daughter stay home to help her with household duties. Sometimes a girl is forced to drop out of school when her mother gives birth to care for young children and her mother in puerperal time. The study demonstrates two important issues related to the situation stated above: 1) a mother's denial of her daughter's schooling emanates primarily from her desperate feelings about her own life, as she is overwhelmed with domestic work and unaware of the benefits of educating her daughter. Such a mother said, "what good is an education while I am suffering with continuous domestic work burdens". 2) She might consider having her daughter leave the house early and deal with her own life through early marriage. A large body of literature has shown that education helps women to engage in a variety of personal, family and community affairs (Ahmed, Creanga, Gillespie & Tsui, 2010; Gordon, et al., 2011; Saleem & Bobak; 2005), but there is not enough research exploring how contraceptive use relates to women's education and the education of their daughters. In the study, it would appear that the complicity of women is a contributing factor to the lack of education, which seems to echo feminist theories that discusses how women are not only oppressed, but often complicit in women's oppression themselves (Bielkiewicz, 2011).

This dynamic not only denies the privilege or right of a girl to attend school but also disgraces her human dignity. In line with this, some rudimentary attempts towards girls' school attendance are prematurely cut off by early marriage (including marriage by abduction). Refzer (1996), from the Marxist feminist view, argues that woman's oppression results from social arrangements inherent in a society, which can be changed. According to Refzer, family dynamics result in women's subordination since these are based on dominant and subordinate

roles legitimized by society. Some of the women in the study were observed to exhibit rudimentary changes in their thinking in this regard, stating they wish better futures for their daughters. At least some of the participants discussed how contraceptive use enabled them to send their daughters to school, or to continue their schooling after dropping out due to forced marriages. Contraceptive use has hence shown that it *can* emancipate and empower women by allowing some of them to complete their secondary schooling, join tertiary school, graduate, and become employed in better paying jobs - but that it is not a straightforward path.

The connection between economic and educational empowerment is thus: contraceptive use was helping women to generate greater revenue, which could go towards their children's schooling. This finding is further supported by a USAID report that showed that couples with the means to control their fertility were often able to invest more resources in each child, which ultimately raises the standard of health, education, and wealth in the population (Frenette, 2011; LeVine, LeVine Schnell-Anzola Rowe & Dexter, 2012; USAID, 2006).

Personal autonomy and decision-making. Women's autonomy and decision making capacity is affected by several factors. Unregulated fertility is one of the major factors that limit women's capacity. Women's experiences have revealed that contraceptive use has helped in myriad ways. It helped the women to plan pregnancy and childbirth and manage their time for personal care and development. Unlike life prior to contraceptive use, they are able to better maintain their cleanliness and improve their self-image and esteem. They feel proud and fortunate to live in a time with available contraceptive services. This finding resonates with other studies conducted on the influence of women's perceived body image on their marital and sexual relations. When women perceive that their body image is poor or weak, they can feel poorly motivated to engage various socio-economic and personal affairs (Ackard, Kearney-Cooke, & Pertson, 2000; Cash, Maikkula, & Yamamiya. 2004; Littleton, Brectkopt & Bernson, A., 2005).

When a woman generates her own income, she obtains relative financial autonomy instead of waiting for money from her husband. Moreover, money she makes can be mobilized for family affairs, particularly for children. Barroso (2010) is in agreement with the experiences of women in this study and states that the ability of women to control their sexuality and fertility through the use of contraceptives creates opportunities for them to be involved in other aspects of life.

Sonifield et al. (2013, p.21) argue that “education, employment, income and relationship stability are connected to mental health, happiness and quality of life for individuals and couples. By affecting these central life experiences, access to contraception may also affect mental health and well-being”. I argue in this study that women’s experiences of psychological empowerment related to personal autonomy following contraceptive use, was encouraging. It is a time when darkness changed into light and nights changed into days. Their fears related to unregulated and unplanned pregnancies have changed into happy and joyful planned outcomes. Contraceptive use has enabled women to postpone pregnancies to a time when they are ready. Not being pregnant when they would prefer not to be has created more time and resources with which to care for their family members and themselves.

Women felt confident and stood firm before society instead of feeling shy and looking down: they have received respect and love from their husbands and other members of society. Women’s attitudes and feelings have changed from the hectic and fearful to satisfied, peaceful and stable. Studies agree with the finding that the ability to delay early childbirth has many advantages such as improved chance of earnings, sending children to better schools, enabling them to follow up on their children’s school attendance and improved marital relations by reducing domestic burdens (Goldin & Katz, 2002; Loughran & Zissimopoulos, 2009; Miller, 2011).

Within the study, women’s visibility in society improved because they had enough time to become involved in social activities after completing their domestic work. On top of those women’s capacities to accomplish their duties in the manner that they had desired has greatly improved. Potts and Rosenfield (1990) and Cleland et al., (2006) ascertained that contraceptive use, apart from the socio-economic considerations, allows the attainment of fundamental human rights to choose the number and timing of children. They explain further that contraceptive use created “freedom from the tyranny of excessive fertility” which has been called the fifth freedom, alongside freedom of speech and worship and freedom from want and fear.

Women’s experiences revealed that they were involved in various community affairs following contraceptive use. Women organized themselves into various enterprises where they received credit and were able to mobilize that credit to generate income, save, and spend for their family needs. They were also involved in other community affairs such as leadership positions for development armies, one-to-five networks, and model women groups in the community.

Following contraceptive use, women were able to attend social gatherings, religious ceremonies and access health services. Women's capacity to discuss family matters with their husbands improved as well. They discussed matters such as household expenses, children's education, health services use and income generating activities. Women's experiences in this study correspond with other study findings that when women are able to delay their pregnancy, it helps them reach to the destiny they want and paves the way to becoming involved in socio-economic arenas (Ananat & Hungerman, 2012; Goldin & Katz, 2002; Miller, 2011).

Decision-making processes and actions are among the core aspects expressing women's empowerment. Decision-making usually relates to the level of power one has in the social system. Women in the developing world in general and in rural areas in particular experience challenges related to a very low social status, which hampers their decision-making capabilities both within the household and at the community level. Women's decision-making experiences as they lived through contraceptive use have shown grey areas unlike other dimensions of their empowerment. Women's experiences in their decision-making revealed that they have relative freedom only for domestic decisions such as cooking food, fetching water, cleaning houses, and washing clothes.

Women's capacities to make decisions on major family affairs are contingent on their husbands. With the majority of decisions, the husbands are the ones make the final decision. In order to leave their houses, women often need to notify their husbands. I learned that women have the liberty to make decisions only regarding lower-level domestic work; their power to decide on higher-level issues is diminished. I argue that though there have been some improvement in the process of decision-making through household-level discussions, that the capacity of women to make their own decision is not yet present, thereby indicating the continued imbalance of power between husband and wife. Decision-making ability is one of the least privileged and slow-moving aspects of progress in women's autonomy observed in the study area.

Mobility. Women's freedom, autonomy, and empowerment can be expressed in terms of their ability to move freely out of their houses for various personal, family, and social activities. However, their freedom of movement is influenced by personal and family factors. In this study, I assessed the conformity between women's contraceptive use and physical empowerment through their capacity to move freely when they needed. Women's experiences revealed that

prior to contraceptive use, they were unable to plan pregnancy and childbirth. Subsequent pregnancies occurred before the older baby reached a year old. Sometimes women were unaware they were pregnant until their growing belly made it clear. Having very closely spaced pregnancies and childbirths meant that women remained at home to care for their children. When routine domestic work was added to child care, women were busy to the extent that they forgot how the days and nights passed. In such circumstances, being able to move out of one's house, or even to think of doing so, is very unlikely. The study findings can be indirectly compared to those of Barroso (2010) who argued that proper contraceptive use is a cornerstone in reaching women's potential and protecting their reproductive rights.

In addition to the burden of domestic work, women were not motivated to leave their houses due to their poor physical appearances. They felt that they were weak and emaciated and never dared to be seen by others in such condition. They were hardly able to clean themselves and get better clothes to wear if they wanted to go to market or to participate in social gatherings. Prior to contraceptive use, when women went to the market, their minds were often occupied by thinking of the children left at home unattended, and thus they would return home early and only partially complete their errands. Thus, contraceptive use has not only increased the frequency at which women can leave the house, but also the efficiency and quality of their time and performances outside of the house.

In examining women's experiences after contraceptive use, I have found that their ability to move outside their home has been greatly improved. Contraceptive use has helped them to avoid unwanted pregnancies and all other related drawbacks that have been causes of their domestic traps. Being free from unwanted pregnancies and childbirths means an increased freedom to leave the house when they want to do so. They feel that their previous "prison status", due to unplanned and unregulated childbirths, has now changed to a feeling of liberation and freedom. Freedom of movement for women as a correlative result of contraceptive use has created further opportunity to participate in various economic, personal, social, and religious affairs. Studies in Bangladesh, Bolivia and some African nations have revealed that women's contraceptive has contributed to increased mobility and involvement in many socio-economic activities outside the house (Conde- Agudelo, et al., 2007; Joshi & Schultz, 2005; Longwe & Smits, 2012; Loughran & Zissimopoulos, 2009).

Relational empowerment. Relation-related empowerment is expressed in terms of women's interaction within the household and in the community. Household-level relations include the marital relation and relations with children. This discussion considers both dimensions.

Women's frequent pregnancies and childbirths created other challenges in their lives. Whereas marital relations ought to be mutually satisfying for both parties involved, for the majority of the rural women they were a source of conflict and violence. This is a strong indication of how the power difference functions to humiliate a woman (Dempsey, 2002). In the past, in the absence of a good system and means with which to avert unwanted pregnancies, women lived in terrifying marital relations. They denied the sexual requests of their husbands, for they knew that each unprotected sexual relation carried risks of an unplanned pregnancy. This is in line with findings by Sonfield (2013) and Crissman, Adanu and Harlow (2012) that the emotional and financial demands of caring for a child can also be a source of stress on a relationship, particularly if a couple had not planned to have a child.

Nevertheless, their husbands were in disagreement with their decisions and forcefully pressured them to accept their sexual requests. Husbands considered refusal a sign of disobedience or disrespect. On some occasions husbands thought that their wives might be cheating on them. Consequently, husbands engaged in polygamous marriages with the expectation that when the older wives became weak, unfavorable, and disobedient, new wives would better care for them and respond to their sexual requests. In some instances, women were forced to stay out of their regular bed, as they were with a young baby who could contaminate the husband with urine and feces. Temporary beds are often prepared on the floor (muddy ground) from the leaves of inset (false banana) for a woman to stay with her young baby in a substandard and uncomfortable manner where rodents and insects disturb their nights (Kynaston, 1996).

From a feminist viewpoint, I argue that while reproductive responsibility should be taken jointly between a husband and a wife, denying a woman the right of sharing a bed is inhumane. Studies in Ethiopia and Colombia have also indicated that increased intimate partner violence is related to unintended pregnancy (Berhane, et al., 2001; Deyessa, et al, 2009; Pallitto & Campo, 2005). It is a biological endowment for a woman to bear the fetus in her womb for about forty weeks and breastfeed the baby after birth, but the forced marginalization of a wife for the sake of

child care is an indication that the husband is subjugating her to bear all reproductive and related burdens for his comfort. This finding also explains the notion presented by the Safe Motherhood organization, that lack of support for a woman from her husband and others in domestic work load leads to mother burnout (Safe Motherhood, 2010).

These circumstances not only harm a woman physically but also seriously damage her overall humanity to the extent of denying her human rights (enjoying the right to equal treatment in all life affairs) and privileges. Women felt that bearing children is a natural gift and should be a source of pride; yet this gift has been wielded as an instrument for their oppression and punishment. In addition to losing their physical comfort, women are also subjected to difficulties in their marital relations. When women feel weak and unhygienic due to overwhelming domestic work and a lack of time and resources with which to prioritize their personal care, their husbands easily switch to another marriage and repeat the cycle of devastation in women's lives. Al-Krenawi, Graham and Al- Ghariabch (2011) indicated that husbands often search for a new partner when their first wife ages, leading to increased psychiatric problems for the abandoned women.

Women explained the benefits of contraceptive use on their relationships within the household and in the society as linked with family planning. When women spaced pregnancies and childbirths, they had more time to care for themselves and spend with their husbands. Women's lived experiences related to contraceptive use have revealed that they reached a state where they could clean themselves, eat well and dress well, thus improving their appearances. This has improved their self-esteem and courage to better interact and socialize within their houses and out in the community. In line with this, Ananat and Hungerman (2012) and Goldin and Katz (2002) argue that contraceptive availability establishes strong marital relationships and reduces conflict among partners.

The women in the study who used contraceptives explained that they are not only pleasing their husbands but also enjoying their desires and feelings as women and human beings. They had the time and opportunity to listen to their inner desires and express them openly by engaging in mutually satisfying sexual relations with their husbands and not just passively obeying them. Overall, the women understood sexual relations to the central issue in either strengthening or weakening marital relations. Hence, contraceptive use has improved their marital relations and decreased the likelihood of polygamous marriages, as husbands were

satisfied with their wives. There is a dearth of supportive evidence in this area but some studies argue indirectly that women's contraceptive use increases their social network. Women's experiences in discussing their fertility demonstrate that their experience in discussing reproductive affairs has increased with contraceptive use (Irani, Speizer & Fetso, 2014; Leon & Lundgren, Sinai, Sinha & Jennings, 2014).

Towards an enabling environment for contraceptive use. Discussion about the perception of study participants regarding the environment related to contraceptive service includes: 1) the service organization considering the accessibility, availability, acceptability, and convenience for use, 2) the rights premises for service provision and 3) special contributions of the health extension program as an innovative primary health care approach towards contraceptive service.

Contraceptive service organizations (content and process). Contraceptive service provision has existed in Ethiopia for the last five decades, though the level of service quantity and quality has differed over years. At the early stages of service provision, it was centralized in major urban areas and then slowly decentralized and integrated into the broader health care system. In this study I conducted quantitative analysis of five years of retrospective data from nine health posts and conducted a qualitative analysis of the environment with respect to service availability, accessibility and convenience of use from the perspectives of service providers and health managers.

The discussion takes into account both the quantitative and qualitative study findings. The study has indicated that until recently, service access and availability were weak in most parts of the country. Both quantitative and qualitative study findings confirm this, as for instance, at the early stage of the health extension program only oral contraceptive pills were available at the health post level. Now the mix of methods available includes both short acting methods (pill and injectable) and long acting methods (Implanon) at the health post level through the health extension program. The availability of more methods increases as one goes up in the hierarchy of health services delivery.

Consistent experiences were observed among service users, services providers and health services managers with regards to contraceptive service availability, accessibility, and convenience. This indicates that there are some improvements in coordination and communication among stakeholders related to the service processes and contents. With the

exception of a few, all of the participants' experiences showed that contraceptive service availability, accessibility, and quality are improving. Some peculiarities are experienced with regard to the availability of contraceptive methods, specifically injectable contraceptives. Service providers at the health post level and district health managers claimed that they face occasional supply shortages of injectable contraceptives. However, health services managers at higher levels such as the regional health bureau and federal ministry of health disagreed on this point.

I argue that the gap in supply chain management observed from top to bottom is an indication of the fragility in management systems. This shortage is especially problematic because the injectable contraceptive method is the most commonly used among rural women. Nearly two-thirds of women are currently using an injectable method. This is also in line with the reports of the EDHS in 2006 and 2011. The study also found that women are sometimes forced to switch from one method to another one due to shortages of their method of choice, namely injectable contraceptives. I also argue that lack of a particular method, such as an injectable contraceptive (which is more likely to be accepted by users), may be a challenge to the further expansion of contraceptive use and in creating sustainable service (Karim, Bieze & Chimnani, 2008). Switching from one method to another ought to be due to defined medical reasons or the choice of the client, but the current shortage-related switching is another hindrance that may overshadow service quality and expansion. I argue that this could hamper contraceptive service expansion and negatively affect good feedback toward the HEP. This is in contrast to established service norms in which service delivery should provide adequate attention to socio-cultural and personal experiences (MSH, 2011; Prata et al., 2011; Solar & Irvin, 2007).

In this study I have examined the processes that support the provision of high quality contraceptive services. The study revealed that the majority of contraceptive users access services from health posts. Health extension workers are the primary providers of the service. In order to provide comprehensive services for users, service providers need to be better equipped with basic competencies and regularly updated skills. In order to improve the service, providers' competencies at the grass roots level (health extension workers) and the next level up (the health center) reference materials such as manuals, leaflets; flips charts etc. may be used. The availability and experiences of the use of reference materials is examined in this study from the perspectives of service providers and managers and direct observation during field visits.

Higher level health service managers argue that they have prepared and distributed standard supportive documents in the form of manuals, flipcharts, and leaflets based on the demand and request of regions. Most health extension workers for their part expressed that the available reference materials are adequate in guiding their service provisions. However, some service providers shared their feelings that the materials are inadequate or incomplete for the competency required for service provision. I argue that service providers' level of competency requires that they be readily provided with reference materials (and that the materials are comprehensive and easy to understand and use) so that they can properly use the materials and act accordingly. Service providers' competency is crucial for initial service start-up and subsequent continuation of service provision. The findings from USAID-Deliver (2013), argue that proper method choice and sustained use is dependent on the information clients receive from providers.

Why Rights Matter: The broad premises and rationale of providing contraceptive service. I examined the broad premise of contraceptive service provision with consideration for its historical trends and current state. Contraceptive services have been provided since their inception under three major rationales: demographic/economic, health, and human rights/reproductive rights. The level of emphasis and direction given to contraceptive service and the underlying rationales differ across the world depending on the context of each nation. However, global consensus was met to provide contraceptive services based on human and reproductive rights at the 1994 ICPD conference in Cairo. In connection to this, I examined this rationale which is prominently governing contraceptive service provision and to what extent the human rights and reproductive rights rationale is functioning in the study area. This is also related to the intention of discerning connections between service provision and women's health and empowerment from the rights perspective that is central to this study.

Service providers and health managers revealed differing experiences with regard to the ultimate rationale for contraceptive service provision. Health managers at higher levels of the health system clearly internalized the broad premises of providing contraceptive services throughout the country. Their experiences showed that Ethiopia, as one of the UN member countries and a signatory of the ICPD plan of action and related treaties, has endorsed the rights rationale as the backbone for reproductive health service provision. They expressed that health in general and reproductive health in particular is human rights, to which Ethiopia is committed

in any social, economic and political dimensions. This was enforced by clearly situating the issue in the national constitution. The revised reproductive health strategy of the country confirms that provision of contraceptive services is part of reproductive health under the rights rationale, and is a priority of the country. The experience of higher-level managers is in line with the international consensus that reproductive health is an inalienable human right and a woman's right. Ensuring reproductive rights through reproductive health service provision from a rights perspective supports the attainment of the highest possible level of reproductive outcomes (Dugassa, 2005; Kaler, 2000; UNFPA, 1997).

However, based on the experiences of other lower-level managers and service providers, I argue that this is not uniformly shared across the health system. I observed a disconnect in thought among various levels of health care workers. When one goes down the hierarchy, it is easy to hear the demographic and economic and health rationales automatically, but the issue of the rights rationale is a gray area. District managers over-emphasized the demographic and economic rationale when considering their district's socio-economic context. They expressed the seriousness of poverty, the ever-diminishing land size, and the loss of agricultural productivity as the reason for their emphasis on the demographic and economic rationale. They ardently expressed that the economic and demographic rationale cannot be overlooked (Bremmer et al., 2012; Degu & Worku, 2009; Getahun, 2010; Sinha, 2003).

The experience of the lower-level health managers and service providers is commensurate to the dominant demographic and economic rationale, despite 20 years of advocacy related to other rationales such as the rights-based approach, economic and demographic rationales outweigh that of the rights rationale. I ascertained that health managers and health service providers strongly emphasized economic and demographic rationales more readily than others. Women's experiences also revealed that the primary purpose for which they are using contraceptive services is related to economic and health issues (Gribble & Boss, 2009; McGinnis, 2011).

The health rationale, with particular emphasis on maternal and child health, is another area that health professionals associated with. They expressed their experiences and attitudes in this regard, stating that contraceptive service is life-saving for both mothers and children. Women's experiences also substantiated this, as their livelihoods and health status has improved since they started using contraceptives. The study showed women's gratefulness to God and the

government for providing access to the services in their vicinities. I argue that women feel that the government offers contraceptive services as a measure of goodwill and blessing, but that they don't see the service as an inherent right that the government is obligated to provide. This may be due to the long-standing reproductive health and livelihood challenges they have faced and their level of awareness of rights and privileges to which they are entitled. The thoughts in this study are distant from those of the ICPD declaration and global agreements that nations have obligation to provide access to reproductive health services, including family planning, to their citizens (Hardee et al., 2014).

I further argue that the reproductive health rationale or human rights rationale for providing contraceptive services is not well communicated and that there is not adequate emphasis on the issue. It can be argued that such undertakings affect the rights of women to make decisions regarding their reproductive health. Moreover, the information gap that existed in the health hierarchy demonstrates that the level of understanding towards rights issues following the ICPD is inadequate or weak. This lack of attention to contraceptive use as a right may negatively influence the rapid expansion of services or their sustained use in the long run. I also argue that a service that "respects, protects and fulfils" reproductive rights enables continuous and sustainable use by reducing the power gaps that exists between the service providers and the women (WHO, 2014).

Whereas contraceptive service has a wide spectrum of benefits and far reaching domains for providing the service, the narrow focus of service only from demographic/economic and health premises limits not only the rapid expansion of service (accessibility & availability), but also the quality and sustainability of service, hence the outcome and impact (WHO, 2014). If contraceptive provision program is established from a human rights perspective across all the service providing outlets, the service will further ensure rapid attainment of global and national development goals by putting women at the center (Cottingham, Germain, & Hunt, 2012; WHO 2014). The human rights approach offers a broad lens for action by being able to envision change in political, economic, social, cultural, and individual spheres. Moreover, providing contraceptive services from rights premises fundamentally ensures the notion that a service should respect, protect and fulfill the human rights (Hardee et al., 2013).

Therefore, the lack of uniformity among the health hierarchy on the rights-based rationale for providing reproductive health services including contraceptives across the health service

delivery continuum, could have been the reason for slow uptake of service and the observed shortage of some of the most wanted contraceptive method (Depo-Provera). I argue that the ‘disconnect’ between the higher level managers and grass root level service providers in utilizing the rights premises is the crucial area that need more attention. The front line health workers acquaintance with the rights perspective is a key in reaching to husbands and elders (Bruce, 1990; Glasier, 2010; Gulzar & Ali, 2008; USAID-Deliver, 2013). Establishing a notion that contraceptive service provision has to consider women as an end but not only as a means is fundamental to ensure the reproductive rights of women (Mohindra & Nikiema, 2010; UNFPA, 2008). When the service provision ensures reproductive rights, the empowerment of women can further be materialized through involving and convincing all stakeholders (such as husbands and elders) that influence and challenge the women status.

The observed disconnect among the service managers and providers towards human rights premises is a deviation from the international agreement for contraceptive service provision, in which the rights approach is embedded. The WHO (2014) guideline clearly stipulates that reproductive services that respect, protect, and fulfill human rights exhibit better health outcomes.

Ethiopia’s health extension program: An important link in contraceptive uptake.

Contraceptive service provision currently exhibits a unique pattern in relation to its coverage and quality. The service has existed for almost five decades, but the rate of service coverage expansion has remained sluggish. As has been indicated in many empirical evidences (EDHS 2011; 2006), the service coverage showed tremendous improvement in contraceptive prevalence. A quantitative finding in this study indicates a similar trend; contraceptive prevalence increased by seventeen percent over five years (2008/9-2012/13 GC), from twenty five percent to forty two percent for modern methods. This finding is higher than the current national coverage.

In this study, I further examined which factors contributed to the remarkable improvement in contraceptive use or whether there is any defined connection to the new innovative community-based health extension program. The service providers, health managers, and service users’ experiences indicated that the health extension program has made a unique contribution to rapidly improving access to contraceptive services and convenience of these services for women. The participants’ experiences indicated that the health extension program, unlike the former strictly institutionalized approach of service delivery, brought services closer

to women where they live and work. Bringing services closer to women has allowed for improved service access and use to suit women.

The services in each *kebele* (health post) have allowed women to easily access the services by avoiding long walking distances, wait times, and requirements of permission from their husbands. When women do not want to disclose their service use to their husbands, they go to the health post as if they are going to a neighbour's house; thus no one can question them about where they are and why they are out. Studies support this finding in that any service to be promoted and used by the target group should fulfill certain conditions including physical, financial, and socio-cultural aspects (Chaya, 2007; Pacque-Margolis & Pucket, 2013; UN, 2013). Bringing services closer to the potential users increases the possibility of actual use (Dynes et al., 2013; Hock et al., 2012).

Another peculiarity of the health extension program in relation to contraceptive service is that the program has removed many obstacles and barriers that hampered women's potential for service use. A unique issue related to health extension workers is that almost all of the health extension workers are women who were recruited from the *kebele* in which they serve. This has removed the gender, language, and cultural barriers between service providers and users (almost all contraceptive users in the study area are women). This experience is in congruence with studies elsewhere that state that the attitude and behaviour of health professionals should align with the society's culture, values, and norms in order to motivate clients to use services (Obrist et al., 2007; Provincial health authority, 2011).

The health extension workers speak the same language, share a similar culture, and are women of the same gender. These conditions have established environments conducive to using and accessing the services that they need. This is evidenced by women's experiences as they proudly show the difference in the patterns of service access by comparing their pre-health extension program service inquiries. They were forced to walk longer distances and required to pay for services and in most cases looked for a translator to explain their feelings to the health professional. By the time they reached the health institutions, they often faced a discrepant gender (male health professionals) or who could not speak their language. As a result, they were not motivated to go to the health institutions to seek services (FMOH, 2008; FMOH, 2006; USAID, 2014).

The health extension program further improved contraceptive service access through the home visiting program. From its inception, the health extension program was mandated to extend health services to the household level through regular home visiting. An increased cultural merit of health extension workers (their better acceptance by community members while visiting homes) is that they were female, unlike their male counterparts who usually were seen suspiciously by the head of the household. This is connected to cultural aspects and the domestic work patterns in which most rural women stay home doing domestic duties, and thus is easily accessible for a health extension worker to provide services during their home visits.

I have also elucidated in the study another dimension of the health extension program from the participants' life worlds related to contraceptive service. Study participants experiences showed that the health extension program had ensured the principles and philosophy of the primary health care in Ethiopia. The program created wonderful opportunities to improve collaborations within and outside the health care systems. The health extension program is closely supported by the health center, where a designated health professional is assigned to regularly supervise and support the health extension workers. The supportive supervision and institutional collaboration continues until it reaches the highest level. The health system closely works with partners at various levels to fill gaps either technically or materially. Many study findings show that health service delivery approaches that do not leave room for inter-sectorial cooperation and that do not ensure community involvement are never satisfactorily accessible, acceptable, or sustainable (Hock et al., 2012; USAID, 2014; WHO, 2012; WHO, 1978; Wickstrom et al., 2013).

The health extension program is also networked at the *kebele* level by closely working with the community. The health extension workers participate in the *kebele* affairs and receive support from the *kebele* administration. They are members of the *kebele* command post, which is responsible for overall affairs. Furthermore, the health extension workers closely function with the women development armies, one-to-five networks, and model household women. This has established strong linkages between the health extension program and the community members at a basic level. Thus, it is through such channels that information and services flow until they reach the household and target woman.

The strong collaboration between the health extension workers and the current women users of contraception has established a synergy in information dissemination channels that

reaches the current non-user women in the community. The current service-user women, through the one-to-five network in their neighborhood, initiate discussion on contraceptive use and its benefits by sharing their life experiences to non-user counterparts. Perry and Roger (2014) argue that if the health service delivery approach offers attention to the multiple dimensions of health determinants and involves all stakeholders, the service uptake increases tremendously. Gulzar and Ali (2008) also agree that client's family planning service use behavior is largely influenced by the relationship between the service provider and client. This study has proved that female health extension workers have greatly improved contraceptive service uptake by extending service to households through the home visitation.

Anticipated challenges of the Health Extension Program

Despite the encouraging success of the health extension program and the overall provision of contraceptive services in new dimensions, it is not free from challenges and shortcomings. In the study I have examined the anticipated challenges from various angles. These roadblocks might impede sustainable service provision and community members' enjoyment of the services. The anticipated challenges as shown from the experiences of the study participants cited barriers of culture and tradition; lack of men's participation in the process of contraceptive use; and a lack of a defined budget for contraceptive services. This resulting dependency on donors and partners; disparities in service use based on age or place of residence (pastoral area, adolescent etc.); and health extension workers' burnout due to high workloads and demotivation.

Cultural practices and beliefs are influential in either enhancing or impeding the progression of service use depending on levels of conformity to the prevailing cultural backgrounds. Culturally-derived desire for large family size in Ethiopia has been one of the obstacles for contraceptive service expansion. Changes in preferences for large families and empowering women took too long, and still remains one of the main challenges contraceptive services face. Old rural men exhibit pro-natalistic attitudes and desires for large families, as suggested in this study. Studies in Ethiopia and elsewhere are in agreement that cultural aspects are crucial in contraceptive service provision. Some conservative cultures where men are dominant become the bottlenecks for the expansion of contraceptive service (Beekle, 2006; Haile & Enqueselassie, 2006; Mekonnen & Worku 2010; Sirkanthan & Reid, 2008).

Men's participation is another area that affects contraceptive use. The study revealed that though some modest improvement is observed with regard to their involvement or favorable decisions regarding their spouses' contraceptive use, there are many others who still do not support service use. Consequently, some women are forced to use the service in secret. This is one of the indicators that contraceptive service provision is not in clear alignment to a human rights premise. The reason for this could be a lack of awareness, traditionally bounded in rural patriarchal hegemony and cultural practices. Most rural men consider childcare to be a solely a woman's concern and never worry about anything connected to reproduction. Other studies support our finding that men have great influence on sustained contraceptive use for themselves and their spouses (Najafi, Rahman, & Juni, 2011; Tulo, Deressa, Ali, & Davey, 2006).

Lack of a clear budget for contraceptive service is another drawback that affects further expansion and improvement of the HEP in both in access and quality. Contraceptive supplies are received from the Pharmaceutical Fund and Supply Agency (PFSA) and distributed to health institutions through the district health office or higher-level health institutions by direct purchase from the agency. However, there is no defined budget that would comprehensively cover all necessary expenses related to the service. Consequently, the service suffers from lack of regular training and motivation of the health professionals. Neither the district health office nor the primary health care institutions are in a position to conduct regular capacity building training. Most service users are still using short-acting methods; a majority are on an injectable method followed by an oral pill. The slow uptake of long acting methods (Implanon) despite their accessibility at health posts is another area of concern and is a challenge to better contraceptive service outcomes. I argue that lack of clear budget allocation within the nation and a huge dependency on donors potentially ruins the sustainability of services (Creanga, Gillespie, Karklin & Tsui, 2011; Jacobstein, 2013; London Summit on Family Planning, 2012; Macha et al., 2012).

From the health extension workers' perspectives, lack of a clear career, being forced to work in one place for an unspecified time, and a lack of adequate incentives and workloads due to ever-increasing task shifting, have all been expressed as challenges. At the early stage of the health extension program, the health extension workers were expected to perform only limited services. However, eventually they were expected to carry out invasive procedures like Implanon insertion and Depo-Provera injection. They were also expected to do antenatal care, referral for delivery, and postnatal care. The health extension workers are worried about the ever-increasing

quantity and complexity of work and mandates given to them. Teklehaimant et al. (2007) argue that placing the health extension workers at the community level is a commendable undertaking but fulfilling favourable working conditions remains a challenge. This is in agreement with the experiences of the health extension workers in this study.

Some health extension workers favourably accept task shifting and job enrichment with new skills and responsibilities, provided that they receive corresponding rewards and supervisions. Some others expressed that they feel exhausted, challenged, demotivated, and burnt-out. As a result, some health extension workers have shifted their jobs and working areas. This is another critical challenge to the program. Failure of the health extension workers to remove Implanon is expressed as one of the serious limitations and a point of confrontation with clients. When women visit the health post seeking services for Implanon removal, a health extension worker refers her to the health center for the same service according to the current protocol. However, the women are mostly unwilling to go to the health center and challenge the health extension worker to remove it right there. They say so because the health extension workers were the one who have inserted it and women expect them to remove it in similar way. Women are not aware of the inability of the HEW to remove it. The “no” response of the HEW to women about Implanon removal has created a feeling of suspicion among women about the capability of the health extension workers.

In this study I have examined the reasons why health extension workers have refrained from Implanon removal after they had inserted it. No clear evidence was found to ascertain the reasons from the study participants. Some of the participants mentioned that Implanon removal procedure is more complicated than the insertion. Hence, they felt that the removal may carry higher risks than the insertion and may be beyond the scope of the health extension worker. On the other hand, the majority of the study participants had no clear idea about the reason. I feel that the reason might be to discourage early removal requests, which would be a draw back for service uptake. I argue that this again violates the rights of the woman and is contrary to what has been indicated in the new reproductive health strategy document and the national constitution.

I want to re-emphasize the basic premise of contraceptive service provision: the human and reproductive rights approach. A series of UN conferences, meetings, and treaties have produced an agreed-upon approach to ensure the reproductive health rights of services users.

Human beings have a right to enjoy the highest level of attainable health, including sexual and reproductive health. They have the right to have means to do so without any discrimination and coercion. Similarly, women have the right to choose a method best suited to her condition and to withdraw from the method when it fails to do so. Either keeping the information aside or limiting service access is an indication that the contraceptive service is not in line with the ICPD plan of action. Hardee et al. (2014) argue that any family planning program has to respect the ICPD plan of action and must guarantee freedom of contraceptive choice and respect, protect, and fulfill human rights.

In order to ensure sustainable provision of contraceptive service and enjoy continuous benefits in multidimensional aspects based on the study outcomes, I recommend the following for government and partners involved in service provision: The government and partners need strong concerns and efforts to inculcate the premises for providing contraceptive services from the agreed up on ICPD declaration and plan of action, and the inclusion in the strategy document should be reinforced through all intervention channels until reaching the beneficiaries. The correct approach, therefore, should give strong attention to conceptual and practical undertakings; such as the following:

1. Both front line health service providers (the health extension workers, nurses and other health care workers) should develop a clear acquaintance to the rights-based reproductive health service delivery approach.
2. Service users ought to be made aware that it is their rights to receive contraceptive services through rights-based education.
3. Strengthen the existing community networks through proper evaluation and feedback and create strategies on how to improve men's involvement in reproductive health services, including contraception, in a manner that respects, protects and fulfills women's rights.
4. Design a clear strategy that allows the wonderful experiences of current service-user women to be shared with their non-user counterparts in order to ensure the expansion and sustainability of contraceptive service.
5. Mechanisms should be designed to encourage and motivate the health extension workers and ensure retention through developing clear career structure, training, and solving issue of transfer and other related elements (financial and non-financial motivation).

Conclusion

This chapter considered the major methodological challenges and attempted to draw out the deeper meaning from the results by comparing the study findings to that of other similar works, and to consider the findings in terms of their practical significance. The peculiarity of the study is its point of departure from the life world of women about contraceptive use. This discussion of the study suggests ideas for moving forward. These directions are presented next.

CHAPTER 6-CONCLUSION

This study was conducted with the broad aim of improving the overall understandings of health and social policy makers, health service providers, service users, researchers, and activists about women's perception of contraceptive use towards health and empowerment and how these experiences would help in improving access and utilization of the service by the current non-user women. The study has also explored the perception of service providers regarding the environment for contraceptive service provision by examining the content and process of service organization. The study took place in Southern Ethiopia in the Sidama Zone, Hawassa University research villages with the expectation that Hawassa University along with its collaborating partners and stakeholders could use the findings to strengthen contraceptive service delivery systems in the study area. I, as a researcher and university instructor at Hawassa University will use the findings to improve reproductive health and health services management curricula, course delivery and advocacy of rights-based reproductive health services delivery. Future research directions and the study recommendation will be implemented in collaboration with other staff members of the university and collaborating line organizations.

A mixed method approach with major emphasis on qualitative design led the study. The approach was influenced by feminist theory and framing. Rural women's experiences were examined in detail from the points of their life world; how they perceive contraceptive service use in relation to their health and that of their children. Contraceptive use-related benefits towards women's empowerment including the economic, psychological, physical, decisional and relational aspects were examined using a phenomenological analysis. In the study I have further examined the service organization patterns and suggested how to ensure availability, accessibility, acceptance and convenience of contraceptive services. My discussion of the trends in contraceptive service availability and use, whether it is improving or not, and what peculiarity has been observed in recent years, focused on the new health extension program of the country given its role as a key pillar of the program.

Based on the study findings it can be concluded that in women's life worlds, the overall use of contraception has created remarkable means for women to control their bodies, their reproduction and their fertility. Contraceptive use has freed women from worries and traps related to unplanned and unwanted pregnancies and childbirths. It has opened wide opportunities for women; it has offered "peace and stability".

With regards to the service organizations process and content, there are encouraging improvements in contraceptive services use both in quantity and quality of services. The contribution of the HEP for these improvements has been unique and it has given a special picture in shaping the ideals of PHC. The study revealed that outstanding inter-sectorial collaboration and community networks function better than any other health programs in the country. Women revealed encouraging involvements in the process of contraceptive service access and use in their organizations such as development armies and the one-to-five network.

Despite encouraging experiences observed, the study has revealed some drawbacks that could act in contrast to the achievement of the desired development goal. Decision-making aspects of women's lives are slow to change. Women's agency is an area that has remained complex. Lack of a clearly designated budget for contraceptive service, a large dependency on donor sources, and weak supply chain management are threats for the smooth running of the services. These create shortfalls in regular refreshment training and supervision. Supply shortage related to one of the most widely used methods, the injectable, is a serious concern for the frontline service providers and contraceptive-user women. As a result, women are forced to switch to other methods or discontinue contraceptive use completely. This may in turn act as a bottleneck for sustainable contraceptive services.

Outstanding gaps have been observed to exist between the dominant rationales upon which contraceptive use is promoted and the reasons for which it is adopted, understood, and organized in light of a human rights perspective. There is a disconnect between high-level health managers and grassroots level managers, frontline service providers and service users in this regard. Women revealed limited progress in challenging power relations at home. Such a disconnect is more crucial because lack of clear understanding and acquaintance of the front line health workers of rights-based service provision is one of the major drawbacks for establishing strong information dissemination to women. This is evidenced by women's explanations of service access as if it has been the good will of the government and God, and in their experiences that illustrate how they continued to occupy passive roles in higher-level domestic decisions.

If a rights-based service provision were the norm, and current service users had a more clear understanding of contraceptive service use as their right, they would hypothetically also challenge the cultural, traditional and patriarchal attitudes impeding continuous and sustained use. In that way, women would further accelerate the cascading of information to non-users by

speaking more openly about contraceptive use and about women's position in society. However, a two-decade long effort of the ICPD declaration and plan of action for contraceptive service provision has not been uniformly communicated across the health systems that in turn would have been among the causes for curtailing the rapid expansion and continuous contraceptive use.

Inadequate involvement of men, the prevailing conservative culture and patriarchal attitudes are still among the challenges for expansion of services to current non-users. The study also revealed that no adequate attention has been in place to include the most influence makers such as men and elders in the process of contraceptive service provision. This has in turn slowed the attainment of desired contraceptive use related outcomes.

Workloads and gradually increasing work complexity through task shifting and a lack of comparable rewards for the health extension workers are other areas of concern that need timely solutions for sustainable contraceptive service provision. Moreover, additions of responsibilities and stakes should carefully consider the basic educational and professional training level and the will of the frontline health workers. Lack of proper consultation of such workers in adding new tasks and responsibilities may lead to fatigue and frustration. Finally, it may jeopardise the motives and energy of the HEWs.

Future Direction/Recommendation

In order to ensure the continuous improvement of women's health and status (rights-based and women-centred), and to establish sustainable contraceptive service organization, it is important to understand the gaps that exist in contraceptive service provision and to find timely remedies to fill the gaps. It is imperative that current primary health care units and community-based organizations develop acquaintance with the rights-based approach, its benefits for the rapid expansion and sustained use of services and most vitally, its significance for women of the study area, and of the country as a whole. This study, therefore, has come up with the following recommendations to ensure evidence-based service provision and to propel contraceptive service use in a way that is consistently empowering:

1. Establish mechanisms to share the experiences of women development armies, a one-to-five networks to expand for the inclusion of men and elders in order to expand contraceptive services to the current non-user and ensure sustainability
2. Further quantitative and qualitative studies are needed to measure the level of effectiveness of community organizations in improving access and quality of

contraceptive services (women development armies, a one-to-five network and model households, etc.)

3. Deeper questions also remain that are deserving of consideration. Why has the rights approach to contraceptive service remained obscure? Other rationales for contraceptive use such as economic and health rationales have been straightforward, translating readily to the practices of service providers - does the lack of uptake and understanding of the rights approach relate to the underlying socio-political context? If so, in what manner?
4. This study was a unique contribution to our knowledge base on contraceptive use in many regards. It was also conducted in a way that reflects issues on the ground and close to home, by a person who will take to heart the results and lessons learned. The study will be an enormous input to the Hawassa University and surrounding community links in three core university missions (education, research and community services).

Final thoughts:

This study of women's experiences of contraceptive use in the Sidama has provided a unique lens into perspectives often neglected in reproductive health studies in Ethiopia. At the end of the day, it is women and their experiences that should lead the provision of service. Their rights must be respected, protected and fulfilled at all times and in all circumstances of their lives. That is my hope and that is our imperative as service providers, researchers and fellow human beings.

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Annex 1. Guideline for training research assistants, data collectors and community leaders

Title of the study: **Contraceptive utilization related benefits**

Introduction:

Purpose of the guideline: The study uses mixed methods approach involving many stakeholders in the data collection processes. In order to ensure and maintain the quality of data and the rights of the research participants in every step of the research, acquaintance of all the research team members with the purpose and detailed procedure of the data collection and other related undertakings is imperative. To suit the diverse nature of research team members, the manual composed of three parts.

- Part one is a training guide for research assistants for the quantitative data collection including the supervisors and data collectors.
- Part-two is for the community leaders who will facilitate the whole process of field works in the selected study *kebeles* including participant selection for the qualitative data collection.
- Part three is for qualitative data collection research assistants.

Part one- quantitative data collectors

Six data collectors- two from each district and three supervisors- one from each district will participate in the training for three days. A one day initial training by a one day field exercise and a one day discussion on the feedback after field trial will be done.

Contents of the training topics

1. Brief background of the study including purpose and objectives of the study
2. Ethical issue
 - Communication (how to approach the health institution managers and health service providers)
 - o Rapport
 - o Detail explanation of the purpose of the visit to the particular health institution
 - o Acknowledgement
 - Conform to the rules and regulation to the health institutions
 - Respect both the individuals and culture of the organization
 - Present a copy of permission letter to the relevant authority of the health institution
3. Detailed discussion on the data collection checklist
 - Presentation of the checklist to the participants
 - Stepwise and one-by one reading and discussion what does every statement mean
 - Actively involve the trainee in the discussion
 - Encourage to ask question

- Before field exercise, do class exercise and group discussions on the overall process and on the checklist
- 4. Conduct field exercise
 - Choose one health center and one health post outside the actual data collection site and deploy the participants to gather data based on the checklist
- 5. Conduct feedback discussion after field exercise on the experiences and challenges if any. Discuss how to incorporate some suggestion after the field exercise.
- 6. Windup the training by revitalizing the purpose of the study.

Part two- Community leaders

A total of 20 community leaders-two from each study *kebele* will be enrolled in the training. The purpose of having two leaders from each *kebele* is to minimize chance of absenteeism as they are busy some times and the rural *kebele* is wide enough to be covered by one person alone.

Contents of the training topics

1. Brief background of the study including purpose and objectives of the study
2. Ethical issue
 - Communication (how to approach the women). The community leader has close tie with the women in their *kebele* that they better know how to communicate. However, providing the general direction how to respect and contact from the purpose of the study and ensure the ethical perspective in behavioral research.
 - o Rapport
 - o Detail explanation of the purpose of the study and their will to participate in the study
 - o How to clearly inform the woman about their right to participate or not to participate in the study without any influence
 - o Acknowledgement
 - Respect the woman and her family members during the visit
 - Present a copy of consent form to the woman and read for her if not able to do so

Part three- Qualitative data collection assistants

In collaboration with the researcher, the research assistants will play crucial roles in obtaining quality and rich data during both the key informant interview, focus group discussion and the individual in-depth interview. For this purpose a three days training will be given for two research assistants on the details of the study protocol.

Content of the training material

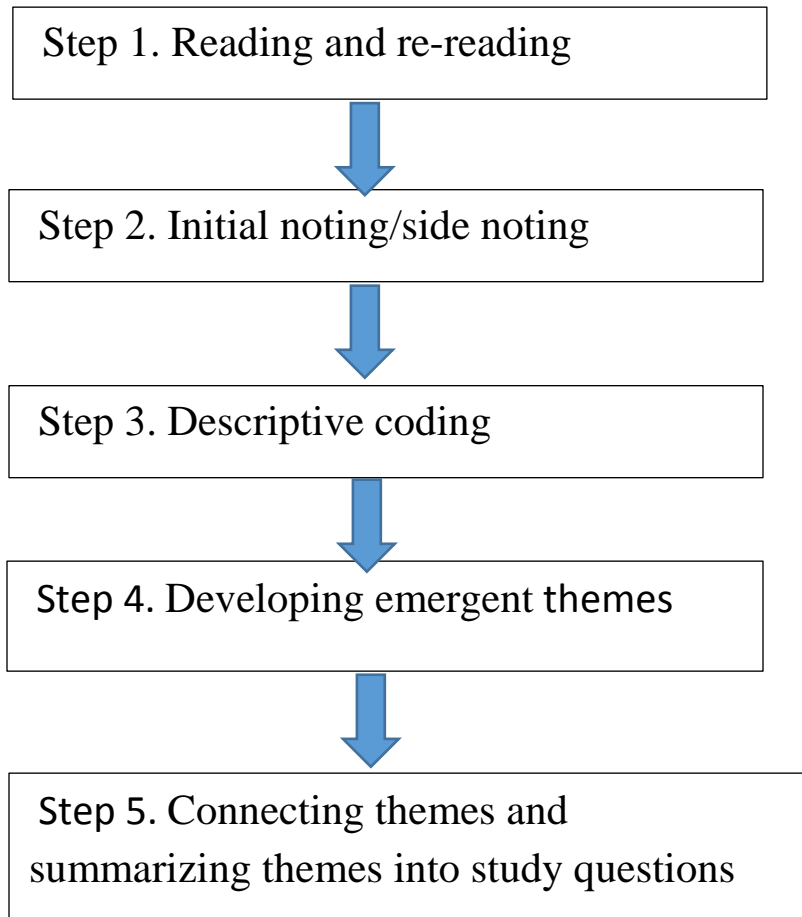
1. Brief background of the study including purpose and objectives of the study
2. Ethical issue

- Communication (how to approach the women). The community leader has close tie with the women in their *kebele* that they better know how to communicate. However, providing the general direction how to respect and contact from the purpose of the study and ensure the ethical perspective in behavioral research.
 - o Rapport
 - o Detail explanation of the purpose of the study and their will to participate in the study
 - o How to clearly inform the woman about their right to participate or not to participate in the study without any influence
 - o Acknowledgement
 - Respect the woman and her family members during the visit
 - Present a copy of consent form to the woman and read for her if not able to do so
 - Maintaining confidentiality and autonomy of the participants at every step of the study
3. Phase two of the study-qualitative methods
- Brief introduction to phenomenological approach
 - o Definition
 - o Variants
 - o Interpretive phenomenology
 - Data collection (details of the procedure on how to gather the information), about note taking, tape/video recording, attentiveness, creativeness, transcription and so on.
 - o Key informant interview
 - o Focus group discussion
 - o Individual in-depth interview
 - Ethical issue
 - o Rights and autonomy of the participants
 - o Avoiding harms
 - o Maintaining personal integrity
 - o Proper explanation of the study purpose, etc...

N.B. Main proposal document is a reference for all the trainings. Emphasis will be given the methodology part inclusive of ethical issue

Annex # 2. Data analysis flow diagram adapted from IPA (Smith, et al, 2009, pp. 82- 100.)

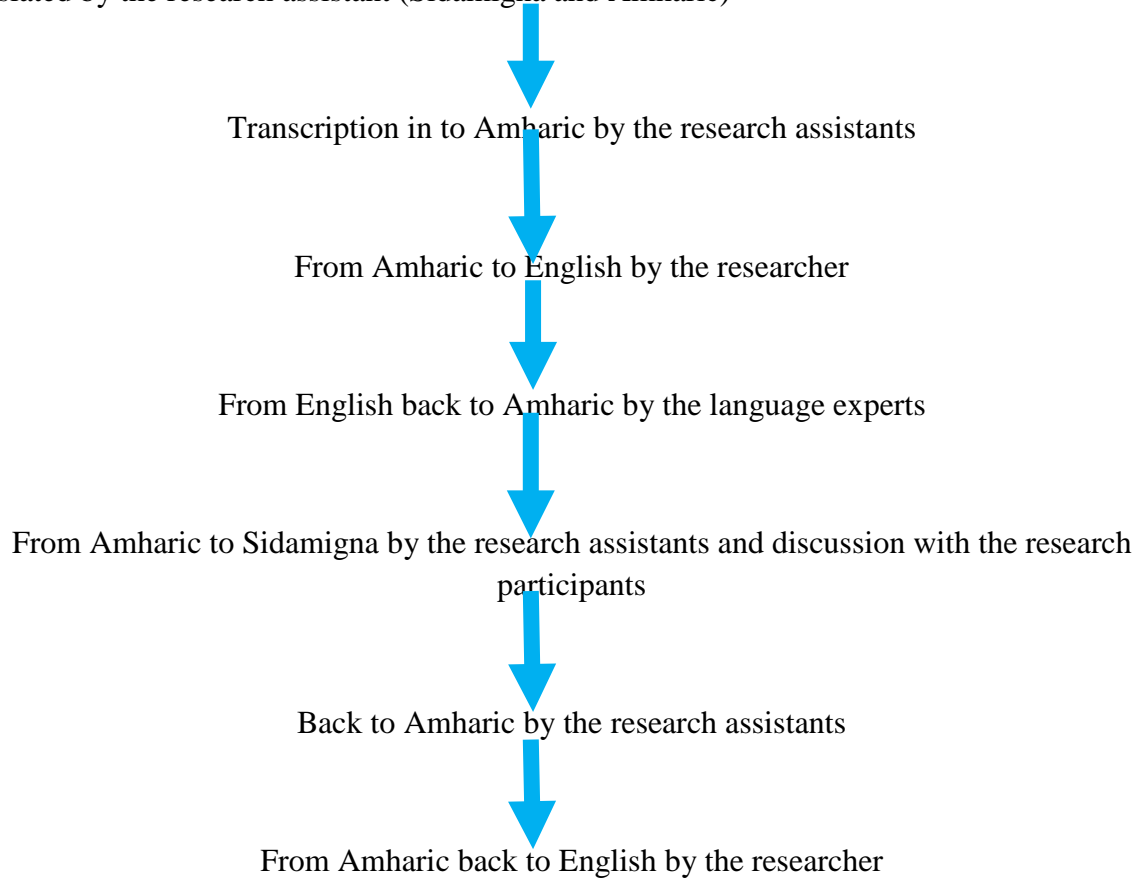
The qualitative data analysis steps adapted from IPA and customized to fit my study taking the following steps as indicated below in flow diagram.



Annex 3. A flow diagram indicating steps in translation

This study involved several participants in the overall processes with various languages background. In order to establish a common understanding and create closeness in the process of the research, use of language translation from one to another has been a necessary condition. Accordingly, the following steps in translation has been taken until the final text took its recent shape.

FGD and Individual in-depth interview conducted by Sidamigna as the guide questions directly translated by the research assistant (Sidamigna and Amharic)



Annex #4. Sample of codes and themes from FGDs and individual in depth interviews

a. Health

Before contraceptive use

Descriptive/exploratory codes	themes
Experienced frequent pregnancies and births resulting in poor maternal and child health outcomes	Compromised maternal and child health
Inability to control one's fertility level/reproductive health; absence to exercise their reproductive rights	Poor health service access/lack of fairness
Reproductive complications due to unregulated/ too frequent pregnancies	Untimely death of mothers/ disabilities
Weak, emaciated and ugly looking children	Child malnutrition and illness

After contraceptive use

Descriptive/exploratory codes	themes
Contraceptive user women ability to postpone or plan pregnancies/child births to the time when they are desirous, hence able to improve the health of their own and that of their children	Improved health status of mothers and children through averting unplanned/mistimed pregnancies/ health related
Creating a harmony between the desired number of children and economic and health status of family (mothers and children, primarily)	Ability to reach to reproductive decision through contraceptive service use
Better time to care for self and children, better feeding and cleaning, better health service access	Improved health literacy and access to health services
Children appeared attractive and grow well through spacing pregnancies	Maternal and child illness and death have reduced

b. Empowerment

Before contraceptive use

Descriptive/exploratory codes

themes

Over ramification and occupied by unbearable domestic duties even their early post partial time. No time to rest be it during pregnancy or early maternity period (psychological and physical)

Great life challenges due to time and resource shortage

Feeling and deep sense of low self- esteem where a woman looks herself down and expression of deeply her life discomfort (psychological)

Dissatisfied life situation created psychological stress and unhealthy feelings.

Experienced liable livelihood mainly trapped in deep poverty; lack of food security at household level (economic)

Abject poverty at household level/economic issue

Inability to acquaint with modern ways of life means to properly shape/see oneself (Physical)

Inadequate knowledge

Extreme feeling and experiences pf poor marital relation largely ended in conflict and violence (relational)

Undesirable and dissatisfying marital relations leading to unstable and discomfort able living situation

After contraceptive use

Dramatic life shift from their previous under recognized and poverty driven situation to a great deal of satisfaction and stable livelihood (Economic)

Improved livelihood situations

Reached into a situation where they can rest and relatively manageable workload (Physical)

Improved time management balancing between domestic work with outside activities and personal affairs

Opportunities created for service users to the extent that they express themselves to others, interact with others. Able to be source of information and pass the information to their neighbors. (psychological)

Improved communication skill and capacities between and across the family and community. Improved relation at family and community level.

Able to engage in various resource mobilization activities and generate money in order to improve household resources and proper ways of utilization. Contraceptive use has created better time for the

Transformation of domestic income and household livelihood through diversified income means.

users to spare for activities other than reproductive responsibilities (economic)

Women experienced happy and joyful lives with expression of their inner pleasant feeling by giving thanks to their Lord and the government.

Consideration as a most privileged member of the society to see such bright time as their worries and stresses are reduced (psychological)

Improved social status, involvement in community affairs and got freedom to move outside their houses and able to engage in various socio-economic activities, generate one's own income and mobilize it.

Improved mental status and developed positive life dimensions

Improved decisional power and social status.

Visibility in the community

Educational issues: Before contraceptive service use

Descriptive/exploratory codes

Lack of time and awareness about schooling hampered their chance of being educated. The underlying traditional and cultural influences such as marriage by abduction distracted female education. Less attention were given for female education. Feeling of regretfulness for their fate, uneducated/illiterate

themes

Inability to use contraceptive service and failure to plan pregnancies have in general affected the education of women and their daughters.

After contraceptive use

Ability to plan pregnancy has created better chances for sending their children to school by fulfilling school inputs.

Contraceptive use has been a remedy for female education by minimizing maternal domestic workload through averting unwanted pregnancies

Contraceptive use has created wonderful opportunities for mothers to better care about their children in school, thus improved their children's school attendance and performances.

Some women were able to continue their dropout schooling from where they have done for early marriage and now completed their secondary and tertiary schooling.

Though female children able to attend school, there

Female school performance is affected by the

is still differentials treatment between male and female children. While males are playing or studying after school, females are expected to engage in domestic work to support their mothers. (differing opinion)

prevailing societal and family attitude.

Annex # 5. Summary result of further discussion with participants

A. Waycho Kebele

Lived experience before contraceptive use in terms of livelihood

Neglect and unawareness of ourselves, serious shortage of time to care for ourselves. Since we are overburdened with domestic responsibilities, frequent pregnancies and child births; we had no time to care for ourselves.

Some of livelihood other general life problems mentioned are:

- Feeling of discomfort, untidy, foully smelling, trapped by domestic works, preparing food, fetching water, searching fodder etc...
- Full of fear, discomfort and challenges, hectic and worry about unregulated and unplanned pregnancies;
- No means to avoid pregnancies despite desire to do so;
- Inability to say no to sexual relation with husband or able to convince him for the risk despite hating unplanned pregnancy;
- Poor marital relation for fear of the consequence of unprotected sexual relation;
- Totally sign of dissatisfaction on ones live and felt desperate to ourselves and to our God.

Lived experiences of women after contraceptive service use towards livelihood

Contraceptive method use has created opportunities:

- Feel better and comfortable
- Relieved, peaceful and restful
- Able to send our children to school
- Manage our family with minimal resources
- Appeared good, clean, hygienic, well fed
- Lead smooth and better lives
- Improved physical appearance
- Transformed lives
- Avoided complication related to some risky pregnancies
- Helped to lead stable life
- Enabled to involve in income generating activities (such as local small scale merchandizing, herding animals, cultivating backyards, crop production)

- Resource mobilization and utilization
- Harmonized living
- The messy life has been transformed into peaceful one
- Improved marital relations and reduced conflict and disagreement
- Improved our social engagements, motilities and networking

Educational status related experiences

- Recognition and awareness to the benefits of education (education is the future of our children)
- Improved investment on child education
- Improved child caring as prevented unplanned pregnancies
- Able to continue our education from where we dropped out it and in few cases attained higher level education
- Helped to regulate unwanted fertilities and enabled to participate in income generating activities
- Helped to emphasize on our female education
- Female children participate in domestic work after school while males play out. There is varying degree of support
- Helped to better care for our children than they ways we were brought up. We have to show in practice the benefits of contraceptive methods use by sending our daughters to school which many of us missed
- We appreciate how contraceptive service use helped us post pone pregnancies and educate our daughters
- Helped our children stay in school, attain higher level education, opened job opportunity

Had had contraceptive service long back (during our mothers' time), we would have been educated and lived better lives, given better care for our children, would never have been ended in early marriage, improved our overall status and able to compete with males.

Health related lived experiences

- Before contraceptive use my life was burdened with very close pregnancies and child births
- Contraceptive method use helped me in delaying pregnancy, regulate fertility, freed me and helped me to get rest
- Reduced domestic violence (being bitten by husband) for disobeying to share bed with him
- Improved marital relation and satisfaction
- Contraceptive method is good but need better food, however some husbands don't care for this
- Relation improved; laughter, joys and happiness

- Being free from pregnancy related worries, improved couple relations, love and affections, helped to influence husbands' expense to family members. If any disobedience to his sexual relation request at night may result in failure to get food in the whole family. Now thanks to contraceptive method, it has eased all those problems.
- Good health, better feeding, peace and stable life
- Satisfying marital relation and able to better understand each other
- Better understanding about the failure to clearly discuss sexual issue in marital relation is one of the reasons for acquiring sexual transmitted diseases.

Before contraceptive use:

- Very close pregnancies and births depleted my nutritional reserve
- Inadequate intake of food and drinks
- Poor sexual feeling
- Total disinterest to life

But contraceptive method use has changed that conditions: able to avoid unwanted pregnancies and births

- I get better money from my husband to purchase food for my children
- Improved appearance and able to please my husband, catch his eyes, look young
- Reduced attempts to multiple marriage
- Psychological satisfaction
- Improved children health and development

Points added by the participants

Eight women participated in the second round discussion

- They mentioned that women in previous time considered as sub-human or lower in status that enough attentions were denied
- Now we recognize that to be pregnant or not should be at our discretion. We should be able to control our reproduction.
- My husband doesn't know whether I use contraceptive method or not. I take the method but do not want to notify him.

They agreed on the summary points presented above does clearly reflect what they have discussed previously.

B. Ganne Kebele

Contraceptive use and livelihood/economic issue

The lives of women in Ganne kebele before contraceptive use were characterized by having many challenges related to unregulated pregnancies and child births. Much of their time is occupied by either being pregnant or caring for young children. Their children where somehow

emaciated, undernourished. After women started contraceptive use, their livelihoods have been improved. This is further elaborated as contraceptive user women are able to space or totally stop pregnancies. As a result they are also able to engage in some income generating activities like small scale trading, growing backyard vegetable, and herd animals. They are able to construct better house

Generally, they mentioned that they are comfortable, feel pleasant; free of burden related to unspaced pregnancies and child care. They got adequate time to care for themselves, wash their clothes, their body and maintain hygiene. Some of the current contraceptive users tried sharing their good contraceptive use experiences with their non-user neighbor women. They act as role models. They use a wide range of contraceptive methods (short acting to long acting). Few of them are also on permanent method (tubal ligation). However, the majority use short acting method, the injectable.

Contraceptive use has helped women to manage their body. As it has created opportunities for them to have better time and balance work and rest, their physical health have improved. Most of women/participants were thankful to the God and the government for having the service at their age.

Contraceptive service acted as a bridge to reconnect couples. A husband who abandoned his wife due to her poor physical and economic status as she gave many children, now came back to her by seeing many changes on her life.

Women have also mentioned their experience as contraceptive use has freed from begging or queuing up for food aid. One woman's experience is that she gave births to eight children before contraceptive service use out of which five were deceased. However since the time of contraceptive use, her livelihood showed improvement.

Contraceptive use and education related lived experience

To mention the relation of contraceptive use to education, let me say something about the early time. Access to contraceptive service was limited to urban setups where few educated women only had the service outlet. Thus, lack of access to contraceptive service forced us to have many children. Having many children clearly interfere with children schooling. It was difficult for parents to send all children to school when the number of children is beyond their income level. Experiences of women presented by comparing this time with their mothers' time. Most of the participants' mothers had many children (beyond eight). Old mothers were really suffered much on caring for all their children. There are some women still have huge number of children and face similar suffering like their mothers. Some of the participants reduced the number of children to four and five. One participant mentioned her experience by saying that "I have four children and now using contraceptive method. I don't want to have more children". They also shared their experience of sharing the issue with their daughters. One participant mentioned that she tells her daughter not to have more than two children in her time. They mentioned that now

they are aware of having many children is a bottleneck in many ways. With regard to contraceptive use and education, participants mentioned that they send their children to school when their age is suitable for that.

They send both females and males. Some of them expressed their special interest in their daughters' education. They did mention so with a sort of regret and anger that had they had knowledge and access to such a service long back, they could have achieved better educational status.

In past in Sidama culture, little attention was given for female children. However, the trend is changing from the past. We see our male and female children in the same way. We send them both to school. The gap that exists between male and female in education is being narrowed. Knowing all the pros and cons of female education, I encourage my daughter not to miss even single class. I always feel desperate when I think about my education. I was forced to stop my schooling from grade four.

Women's lived experiences of contraceptive use and health related issue

Contraceptive use has clear benefits to our health and that of our children. As it creates opportunities for us to involve in income generating activities, we are able to boost our household income. We are now able to expend better for our household; we buy better food and eat well. It helped to prevent unwanted pregnancies and regulate family size. By doing so, it reduced pressure on meager resources. Contraceptive service has direct health benefits to women. Preventing or spacing pregnancy for a woman means, creating better time to maintain her health, eat well etc. It frees her from pregnancy related complications.

There is an experience of conflict between a husband and a wife due to wife's use of permanent contraceptive method (a tubal ligation). Some husbands are supportive to their wives contraceptive use and others are opponent for the service. Husbands oppose mostly the long acting or permanent methods.

All except one participants agreed that contraceptive service use has helped maintaining their health status. Even though they experience some side effects of contraceptive methods, the benefits outweigh that of the side effects.

In very rare case, there is intolerable side effects that had compromised the health of service user. She mentioned that she had continuous head burning sensation, feeling of pain at her joints and general weakness. Most participants expressed their agreement on their experiences on sexual relations with their husbands since they have started using contraceptive services. Their relations have greatly improved as manifested by establishing peaceful life, harmony and satisfying one another mutually.

Points added:

About right issue:

My husband is not supportive for contraceptive use. He oppresses me, he wants me to have as many children as he wants. But, my older children always are in conflict with his idea. They say to me that “what is it mean for you to have as many children as he want? Is that something you feel development or empowerment?” (አንቺ መመርቅ ድግሪ ወይኛም ዲፕሎማ መጫን መሰልሽ እንደ በየአመቱ ልጅ የምትወልጃው አያሉ ነው አገልግሎቱን አኝዲጠቀም ያደረጉኝ).

Majority of women in the kebele understand and agree about contraceptive service and use. Women mentioned that the health extension worker in collaboration with the women development armies work aggressively to enroll none users. The problem in Ganne related to contraceptive services is that of men. Men, largely seem outside the circle and still want to dominate women. They don't want to free their women. Therefore, some of them are not supportive. We now are aware of the benefits of contraceptive use and need encouragement from all the community, government and our husbands.

C. Discussion with the Head of Dale District Health Office

Power presentation of the summary result.

Presentation done based on the thematic area/ research questions and objectives. Comments received from the district head include:

- About the contraceptive service coverage- the district head accepted that presumed contraceptive service coverage of 70-80% has to be corrected as 47%.
- Under the guiding question of challenges for contraceptive service provision; the prevailing cultural problems and gender discrepancy are the most prominent ones that needs emphasis.

D. Discussion with health extension workers (from Gane, Gegara, wiacho, Konsore fullasa and Baja fabrica)

Summary points of the previous discussions was presented to each health extension worker and all have mentioned their agreement on the summary result.

Annex # 6. Instrument/ data form for quantitative data collection

Department of Community Health and Epidemiology, College of Medicine, University of Saskatchewan

Quantitative data collection checklist:

1. District: _____
2. Kebele: _____
3. Fiscal year: _____
4. Total population: _____
5. Reproductive age population: _____
6. Eligible population for contraceptive service: _____
7. Health institution (name of the health center/health post):

8. The distance of the health institution from the furthest catchment in KM:

9. Means of transportation _____
10. Age in years: _____/year
 - 10.1. 15-19 _____
 - 10.2. 20-24 _____
 - 10.3. 25-29 _____
 - 10.4. 30-34 _____
 - 10.5. 35-39 _____
 - 10.6. 40-44 _____
 - 10.7. 45-49 _____
11. Marital status:
 - 11.1. Married
 - 11.2. Not married
 - 11.3. Divorced/separated
 - 11.4. Widowed
 - 11.5. Others/specify _____
12. Duration of contraceptive use: in months/years, specify

- 12.1. < 1 year _____
- 12.2. 1-2 years _____
- 12.3. 2-5 years _____
- 12.4. >5 years _____

13. Contraceptive methods used

- 13.1. Pills _____
- 13.2. Injectable _____
- 13.3. Implant _____
- 13.4. Condom _____
- 13.5. IUD _____
- 13.6. Others _____
- 13.7. _____

14. Reason for contraceptive use:

- 14.1. Spacing pregnancy/child birth _____
- 14.2. Limiting child birth _____
- 14.3. Medical reason _____
- 14.4. Others _____

15. Number method switching: _____

16. From which method to which method _____ to

17. Reasons for switching:

- 17.1. Due to intolerable side effect _____
- 17.2. Failure of method _____
- 17.3. Lack of previous method _____
- 17.4. Any other reason, _____

18. Source of contraceptive supply: _____


19. Frequency of obtaining the supplies: _____

20. Budget allotted for family planning service, if separate and
available _____ BIRR/annum

Annex 7. List of the Millennium Development goals and their relation to gender perspectives (the relation is not strict)

S.no	The Millennium Development Goal	Relation to gender perspective	Remark
1	MDG 1. Eradicate extreme poverty and hunger	direct	Poverty largely affects women
2	MDG 2. Achieve universal primary education	direct	There is gap in schooling between male and female
3	MDG 3. Promote gender equality and empower women	direct	Women are less privileged in many developing world nations
4	MDG 4. Reduce child mortality	indirect	
5	MDG 5. Improve maternal health	direct	Directly affect women's health
6	MDG 6. Combat HIV/AIDS, malaria and other diseases	indirect	
7	MDG 7. Ensure environmental sustainability	indirect	
8	MDG 8. Develop a global partnership for development	indirect	

Annex 8. Ethical clearance from U o S

 UNIVERSITY OF SASKATCHEWAN		Behavioural Research Ethics Board (Beh- Certificate of Approval
<hr/>		
PRINCIPAL INVESTIGATOR Lori Hanson	DEPARTMENT Community Health and Epidemiology	BEH# 13-189
INSTITUTION(S) WHERE RESEARCH WILL BE CONDUCTED University of Saskatchewan		
STUDENT RESEARCHER(S) Abraham Alano Ali		
FUNDER(S) UNIVERSITY OF SASKATCHEWAN HAWASSA UNIVERSITY		
TITLE Contraceptive Utilization and Related Benefits Toward Women's Health and Empowerment in Sidama Zone, South Nationalities and People's Region Ethiopia		
ORIGINAL REVIEW DATE 03-Jun-2013	APPROVAL ON 25-Sep-2013	APPROVAL OF: Application for Behavioural Research Ethics Review Participant Consent Form Key Informant Guide Focus Group Guide Individual in-depth interview guide Acknowledgement of: Institutional Review Board Approval Hawassa University TCPS2 CORE Tutorial Certificate of Completion Abraham Alano
EXPIRY DATE 24-Sep-2014		
Full Board Meeting <input type="checkbox"/>		
Delegated Review <input checked="" type="checkbox"/>		
CERTIFICATION The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.		
Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.		
<hr/>		
Please send all correspondence to:		Research Ethics Office University of Saskatchewan Box 5000 RPO University, 1602-110 Gymnasium Place Saskatoon SK S7N 4J8 Telephone: (306) 966-2975 Fax: (306) 966-2069


- 2 -
PRINCIPAL INVESTIGATOR
Lori Hanson

DEPARTMENT
Community Health and Epidemiology

Beh #
13-189

ONGOING REVIEW REQUIREMENTS

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: http://www.usask.ca/research/ethics_review/




Beth Bilson, Chair
University of Saskatchewan
Behavioural Research Ethics Board

Please send all correspondence to:

Ethics Office
University of Saskatchewan
Room 306 Kirk Hall, 117 Science Place
Saskatoon SK S7N 5C8
Telephone: (306) 966-2084 Fax: (306) 966-2069

Annex 9. Ethical clearance from Hawassa University

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HAWASSA UNIVERSITY
COLLEGE OF MEDICINE AND
HEALTH SCIENCES
Institutional Review Board

ቁጥር: FPB/175/05
RefNo
ቀን: 28/08/13
Date

Research Ethical Clearance

Name of Researcher/s: Abraham Alano, Lori Hanson, W/ro

Topic of Proposal: Contraceptive utilization and related benefits toward women's health and empowerment in Sidama Zone: South Nations, Nationalities and People's Region, Ethiopia.

Dear Sir/Madam,

The Hawassa University, College of Medicine and Health Sciences Ethical Review Board has reviewed the aforementioned project proposal with special emphasis on the following points:

1. Are all principles considered?

1.1. Respect for person:	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
1.2. Beneficence:	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
1.3. Justice:	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
2. Are the objectives of the study ethically achievable? Yes ☒ No ☐
3. Are the proposed research methods ethically sound? Yes ☒ No ☐

Based on the above-mentioned ethical assessment the IRB has:


- A. Approved the proposal for implementation ☒
- B. Conditionally Approved ☐
- C. Not Approved ☐

Best regards,

CC:

- Head, CMHS

Techalew Shimelis W/Kiros
Institutional Review Board
Chairperson




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1560 Hawassa

Annex 10. Support letter from SNNPR Health Bureau



የደቡብ ብሄሮች ብሔረሰቦችና ሕዝቦች ክልላዊ
መንግሥት ጤና ቢሮ
South Nations Nationalities and People's Regional
State Health Bureau



ቁጥር የ፪፻፩-240/1327
Ref. No
ቀን 24/11/05
Date

ለ ሲዳማ ዞን ጤና መምሪያ:- ሃዋሳ
ለ ወላይታ ዞን ጤና መምሪያ :-ሶይ

ጉዳዩ፣ ለጥናት ስለሚደረግ ትብብር፡-


በሐዋሳ ዩኒቨርሲቲ መምህር የሆኑት አቶ አብርሃም አላኖ የPHD ትምህርታቸውን በካናዳ
Saskatchewan University ሲከታተሉ ቆይተው የምርምር ጥናታቸውን " Contraceptive Utilization and
Related Benefits forwards Womens Health and Empowerment in Sidama and Wolaita
Zones,SNNPR,Ethiopia." በሚል እርዕስ በተጠቀሱት ዞኖች ላይ ለማካሄድ ከሚመለከታቸው
ተገቢውን የሥነ ምግባርና ሌሎች መረጃዎችንም በመያዝ ለሥራው ትብብር ጠይቀዋል፡፡

በዚሁ መሠረት ጥናቱ መሠረታዊ ጠቀሚታ ያለው በመሆኑ ለጥናቱ ለሚመጣው ባለሙያ
አስፈላጊውን መረጃ በመስጠት ተገቢው ትብብር እንዲደረግላቸው እናሳስባለን፡፡


አንድም እናት በወሲድ ምክንያት መሞት የሰባትም!

ግልባጭ፣

- ❖ ለጤና ቢሮ ኃላፊ ጽ/ቤት
- ❖ ለጤና ምርምርና ቴክኖሎጂ ሽግግር የሥራ ሂደት ሃዋሳ
- ❖ አቶ አብርሃም አላኖ



አንቀሳቂ ሽብሩ አሰጋሽን
Endashaw Shibru Asegahegn
የጤና ምርምርና ቴክኖሎጂ ሽግግር
ደጋፊ የሥራ ሂደት ባለቤት
Health research and technology
transfer support process owner



☒ 149	☐ {20-92-09}	Fax ☐	20-57-92	E-mail	snnpdhl@telecom.net.et	Code 251-0462
Awassa	{20-59-50}		20-59-55		snnpdpd@telecom.net.et	
	{20-92-08}		20-54-09		snnpdhiv@telecom.net.et	
	{20-54-06}					
	{20-02-32}					

Annex 11. Support letter from Sidama Zone



ቀጥር 1052/598/1
 Ref.No
 ቀን 3/12/05
 Date

Sidaamu Zoone Gashshooti Giddo Fayyimmate Biddishsha

በሲዳማ ዞን አስተዳደር የጤና መምሪያ

ለዳሌ ወረዳ ጤና ጥ/ጽ/ቤት፡ይ/ዓለም

ለቦሪቻ ወረዳ ጤና ጥ/ጽ/ቤት፡ይርባ

ለወንዶ ገነት-ወረዳ ጤና ጥ/ጽ/ቤት፡ወንዶ ገነት

ጉዳዩ፡የጥናት ትብብር እንዲደረግ ስለመግለጽ፡፡

በሀዋሳ ዩኒቨርሲቲ መምህር የሆኑት አቶ አብርሃም አላኖ የFHD ትምህርታቸውን በካናዳ ሀገር በሚገኘው የሳስካቲቸዋን ዩኒቨርሲቲ (University of Saskatchewan) ሲከታተሉ ቆይተው የትምህርቱ አካል የሆነውን የምርምር ሥራቸውን "Contraceptive Utilization And Related Benefits towards Womens, Health and Empowerment in Sidama and Wolaita Zones, SNNPR, Ethiopia" በሚል ርዕስ በዘናችን ካሉት ወረዳዎች መካከል የሀዋሳ ዩኒቨርሲቲ የምርምር ሳይት ሆነው ከተመረጡት ውስጥ በሶስቱ ወረዳዎች ምርምራቸውን ለማካሄድ ትብብር ጠይቀዋል፡፡

በመሆኑም ጥናቱ በዘናችን የሚከናወነውን የእናቶችና ህፃናት ጤና ክብካቤ ጋር ተያያዥነት ያለውና ወደፊት ውጤቱም ለፕሮግራሙ መሻሻል አስተዋጽኦ የሚያደርግ በመሆኑ ለጥናቱ ለሚመጡ ባለሙያ አስፈላጊውን ትብብር እንዲታደርጉላቸው እንጠይቃለን፡፡

እንደም እናት በወሊድ ምክንያት መሞት የለባትም!

ግልባጭ

ለበሽታ መከላከልና ማሳደግ የሥራ ሂደት



ለአቶ አብርሃም አላኖ

ሀዋሳ




Bilbila	046-2206337	ፋክስ 0462204723 ፖስታ 51
ስልክ	046-2200268	
	046-2212945	
	046-2212946	
	046-2215065	

Annex 12. Sample letter of support from study district

በደቡብ ኢትዮጵያ ህዝቦች ክልላዊ መስተዳድር
በሲዳማ ዞን የዳሌ ወረዳ ጤና ጥበቃ ጽ/ቤት
Wodidie Itiyophphyi Manni Gasshooti Giddo
Sidamu Zone Daalle Woradi Fayyimmate
Agarooshsh Borro Mine



ቁጥር: 20/500/1/36
Ref.No.
ቀን: 08/12/08
Date


ጋራ
የደቡብ ኢትዮጵያ
ህዝቦች ክልላዊ መስተዳድር
ለ----- ጤና ኬሳ

ጉዳዩ፣ ትብብር እንዲደረግላቸው ስለመጠየቅ ይሆናል

ከላይ በርዕሱ ለመግለጽ እንደተሞከረው በሀዋሳ ዩኒቨርሲቲ መምህር የሆኑት አቶ አብርሃም አላኖ ለPHD ትምርታቸው ምርምር ለማካሄድ እስከ ቀበሌያችሁ ስለሚመጡ ለሚፈልጉት መረጃ አስፈላጊውን ትብብር እንድታደርጉላቸው እንጠይቃለን፤

አንድም እናት በወሊድ ምክንያት መሞት የለባትም!

ግብረኛ
→ 1ኛ ደረጃ አገልግሎት



✉ Virgalem
☎ 0462250394
Fax ☎
E-mail

Annex 13. Sample consent form for Key Informants

በሳስካትቸዋን ዩኒቨርሲቲ ህክምና ኮሌጅ የህብረተሰብ ጤና ሳይንስ ትምህርት ክፍልና በሀዋሳ ዩኒቨርሲቲ የህክምናና ጤና ሳይንስ ኮሌጅ

በቁልፍ መረጃ ምንጭነት ተሳታፊዎች ፈቃደኝነት መግለጫ ፎርም

እንደምን አሉ?

እኔ አቶ

Xmcysso X15

እባለሁ:: የሳስካትቸዋን ዩኒቨርሲቲ ከሀዋሳ

ዩኒቨርሲቲ ጋር በጋራ በሚያካሂደው የህብረተሰብ ምጣኔ አገልግሎት አጠቃቀም በሌቶች ጤናና ሁሌንተናዊ አቅም ማጎልበት ላይ ያበረከተው አስተዋዋጽኦ ጥናት ቡድን አባል ነኝ:: ጥናቱ በዋናነት የሚካሄደው በደቡብ ብ/ብ/ሀ/ክልል በሲዳማ ነዋሪ ወላይታ ዞኖች ነው:: የህብረተሰብ ምጣኔ አገልግሎት በእናቶችና ህፃናት ጤናና የእናቶችን ሁለንተናዊ አቅም በማጎልበት ረገድ ያበረከተውን አስተዋጽኦ አገልግሎቱን በማደራጀትና ተደራሽነትን ከማረጋገጥ አኳያ በአገልግሎቱ አደረጃጀት ሂደትና ይዘት፣ እንዲሁም አገልግሎቱን በሁለንተናዊ ዘርፍ ከመደገፍና ምቹ ሁኔታን ከመፍጠር አኳያ አስካሁን የተደረጉትንና ወደፊት ሊደረጉ የሚችሉትን በሚመለከት ያሉትን የአመራርና ሙያዊ ልምድዎን በጥልቀት በመረዳት አገልግሎት አሰጣጡን ጥራትና ተደራሽነት ይበልጥ ማጠናከር የጥናቱ ዋና አላማ ነው::

በጥናቱ የምሳተፉት ሙሉ በሙሉ ፈቃደኛ በመሆን ሲሆን ከጥናቱ ጋር ተያይዞ ክፍላጎትዎ ወጭ ምንም አይነት ተጽእኖ እንደማይደረግ እናረጋግጣለን:: ሆኖም በሙሉ ፈቃደኝነት የሚደረግ ተሳታፊዎ ጥናቱን ተግባራዊ ለማድረግም ሆነ የአገልግሎቱን ተደራሽነትና ጥራትን ለማሻሻል በሚደረገው ጥረት መተኪያ የሌለው መሆኑን ለማስገንዘብ እንወዳለን::

በዚህ ቃለ-መጠይቅ ወቅትም ሆነ ከጥናቱ ጋር በተያይዘ ማንነትዎን የሚገልጽ ማንኛውንም ድርጊት የማይከናወን መሆኑን እንገልጻለን:: በጥናቱ ማጠቃለያም ሆነ አስፍላጊነቱ ሲታመን በማንኛውም ጊዜ የጥናቱን ሂደትና ውጤቱን ለርስዎና ሌሎች ለሚመለከታቸው ክፍሎች እናሳውቃለን:: አስቀድመን እንደገለጽነው በማንኛውም ጊዜ የጥናቱ ተሳታፊዎች ማንነት ሚገልጽ መረጃ አይያያዝም::

በፈቃድዎ እውነተኛና ተአማኝነት ያለውን ተሞክሮዎትን በጥልቀት ለማበርከት ለመጠይቁ መቅረብዎን እያደነቅን ቃለ-መጠይቁን እንዲንቀጥል ፈቃደኝነትዎን በፊርማዎት እንድንገልጽልን በአክብሮት እንጠይቃለን::

የቃለ-መጠይቅ ተሳታፊ ፊርማ

[Handwritten signature]

Annex 14. Sample consent form signed by FGD participants

በሳስካትቸዋን ዩኒቨርሲቲ የህብረተሰብ ጤና ሳይንስ ትምህርት ክፍል

የቡድን ወይይት ፈቃደኝነት መግለጫ ፎርም

እንደምን አላችሁ?

እኔ አቶ አባላለሁ። የሳስካትቸዋን ዩኒቨርሲቲ ከሀዋሳ ዩኒቨርሲቲ ጋር በጋራ በሚያካሂደው የቤተሰብ ምጣኔ አገልግሎት አጠቃቀም በሴቶች ጤናና ሁሉንተናዊ አቅም ማሳልበት ላይ ያበረከተው አስተዋጽኦ ጥናት ቡድን አባል ነኝ። ጥናቱ በዋናነት የሚካሄደው በደቡብ ብ/ብ/ህ/ክልል በሲዳማ ና ወላይታ ዞኖች ነው። የቤተሰብ ምጣኔ አገልግሎት አጠቃቀም በጤናችሁና ሁለንተናዊ አቅም ከማሳልበት ረገድ ያበረከተው አስተዋጽኦ በሚመለከት የህይወት ተሞክሮአችሁና ልምዳችሁን በናንተ አረዳድና አገላለጽ ጥልቅ መረጃ ማግኘት የጥናቱ አላማ ከመሆኑም ባሻገር አገልግሎቱን ለሌሎችም ተደራሽ እንዲሆን የሚደረገውን ጥረት የሚያሟግዝ ይሆናል።

በጥናቱ የምሳተፉት ሙሉ በሙሉ ፈቃደኛ በመሆን ሲሆን ከጥናቱ ጋር ተያይዞ ከፍላጎታችሁ ውጭ ምንም አይነት ተጽእኖ እንደማይደረግ እናረጋግጣለን። ሆኖም በሙሉ ፈቃደኝነት የሚደረግ ተሳተፎአችሁ ጥናቱን ተግባራዊ ለማድረግም ሆነ የአገልግሎቱን ተደራሽነትና ጥራትን ለማሻሻል በሚደረገው ጥረት መተኪያ የሌለው መሆኑን ለማስገንዘብ እንወዳለን። ከዚህ ጋር በማያያዝ የምናሳስበው ጉዳይ ደግሞ የቡድን ወይይቱን ጀምሮ እያለን እንኳን ያልተመቸው ተሳታፊ ካለ አቋርጦ መወጣት እንደሚችል ነው።

በዚህ የቡድን ወይይት ወቅትም ሆነ ከጥናቱ ጋር በተያይዘ የተሳታፊዎችን ማንነት የሚገልጽ ማንኛውም ድርጊት የማይከናወን መሆኑን እንገልጻለን። የመረጃ አሰባሰብ ባህሪ የቡድን ወይይት እንደመሆኑ መጠን በወይይት ወቅት ተሳታፊዎች ያነሱትን ሀሳብ ሁሉም ተሳታፊዎች በምስጢር መያዝ ይጠበቅብናል። እኛም የጥናቱ ቡድን አባላት የሰጣችሁትን መረጃ ምስጢራዊነትን በመገንዘብ በተገቢው መንገድ እንጠብቃለን።

በጥናቱ ማጠቃለያም ሆነ አስፍላጊነቱ ሲታመን በማንኛውም ጊዜ የጥናቱን ሂደትና ውጤቱን ለናንተና ሌሎች ለሚመለከታቸው ክፍሎች እናሳውቃለን። አስቀድመን እንደገለጽነው በማንኛውም ጊዜ የጥናቱ ተሳታፊዎች ማንነት ሚገልጽ መረጃ አይያያዝም።

በፈቃዳችሁ እውነተኛና ተአማኝነት ያለውን ተሞክሮአችሁን በጥልቀት ለማበርከት የወይይቱ ተሳታፊ ሆናችሁ መቅረባችሁን እያደነቅን ወይይቱን እንዲንቀጥል ፈቃደኝነታችሁን በፊርማችሁ እንድትገልጹልን በአክብሮት እንጠይቃችኋለን።


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